

# World Medical Journal



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## The Future for Global Health Care

**Cecil B. Wilson, MD, MACP**  
**Inaugural Speech**  
**President, World Medical Association**  
**October 12, 2012**



*Cecil B. Wilson*

Members of the General Assembly, colleagues, guests and our hosts the Medical Association of Thailand.

I am honored to serve as President of the World Medical Association.

I am committed to being a voice for the WMA and our profession worldwide.

And as I think about working with the incredibly dedicated members of this profession, this noble profession of medicine, I am enthusiastic and optimistic about the future. I am proud that the World Medical Association provides an important voice and speaks for the medical profession on health-related issues of worldwide significance.

My pledge to you is that in speaking to national medical associations and other organizations around the world I will use my

best efforts to enhance the reputation of the World Medical Association.

As I work with colleagues around the globe, I am reminded of the commitment we all have to the profession of medicine. I am reminded of the similarity of the challenges we face regardless of our country of origin. Reminded, that there are different ways to respond to those challenges – each of which has its own value.

Most of us went to medical school because of the desire to serve the allure of science and, yes, the thrill of achievement, of doing the difficult – the hard stuff, of running the fastest mile, sinking the hole in one, pole-vaulting higher than any other.

In my country its major league baseball's Josh Hamilton of the Texas Rangers hitting four home runs in one game earlier this summer. For you fans of real football, it's Great Britain and Manchester city scoring twice in two minutes to win the English soccer championship – a first for Manchester City in 44 years.

For the future of the WMA and world health my three nominees for the most significant, the difficult, the hard stuff are:

1. The moral imperative of ethics in medicine;
2. The challenge of non-communicable diseases and
3. The threat of climate change.

For this audience of world medical leaders what I am going to talk about may seem a little like stating the obvious. However, I support the rationale that it is important to from time to time state the obvious be-

cause what should be obvious, if never stated, risks becoming not so obvious.

First ethics:

As physicians we must have moral authority and speak and act with moral authority. That means we must speak out on broad public health issues. Doing that makes our message more credible – and more effective – when we advocate on matters of public policy. We are most credible when we speak from a platform based on principle and ethics.

Those physicians from around the world who came together to form the World Medical Association in 1947 recognized this. They understood that an organization was needed to become the authoritative voice on global standards for medical ethics and professional conduct, rather than focusing solely on protecting the interests of the profession. They recognized the importance to the profession of providing guidance, moral support and practical advice. They recognized the importance of endeavoring to achieve the highest possible standards of medical care, ethics and health-related human rights for all people.

From the beginning this intent was codified in our International Code of Medical Ethics and the Declaration of Geneva – also known as the modern “Hippocratic oath”.

Other declarations have addressed issues such as the patient safety, medical ethics and advanced technology, end of life care, access to care, protection of medical personnel in armed conflicts – and more recently the use of social media.



Today the WMA is bigger, stronger and more active than ever before and it serves as a voice recognized the world over. There is perhaps no clearer example of that recognition than the Declaration of Helsinki that advises physicians on doing medical research on human subjects. The Declaration of Helsinki is the loadstone; the North Star if you will that guides physicians, governments and industry in this area. Next month in Cape Town, South Africa the WMA is convening distinguished ethicists, educators and government officials from around the world to look at potential revisions of the Declaration – not to change core principles – but to determine whether more guidance is needed to deal with the complexities of today's world.

But ethical guidance by itself is not enough – hence our additional goals of moral support and practical advice. To that end the WMA is active in making its voice heard: most recently speaking out urging the government of Bahrain to overturn the criminal court verdict of doctors sentenced to jail for providing care to the injured, and calling on the government of Syria and President Assad to protect health care facilities and their workers from interference, intimidation or attack; speaking out in support of professional orders in West Africa, and earlier this year, sending our president Dr. Do Amaral and chair of council Dr. Haikerwal to Turkey where they marched in solidarity with fellow physicians in opposition to threats to professional autonomy and self-regulation.

Now more than ever, this WMA, this beacon of principle and ethics is needed. The WMA is not involved in health care per se, but does have an important role in seeking to influence the environment, the milieu in which health care is delivered – the structure of health care systems.

Which leads to my second point – the challenge of non-communicable diseases. Non-communicable Diseases (or NCDS)

are now the leading cause of death and disability worldwide. And that is true in the developed and the developing world. These diseases including cardiovascular and circulatory diseases, diabetes, cancer and chronic lung disease are expected to increase in frequency and are largely preventable. They are not replacing the existing causes of illness such as infectious disease and trauma, but are adding to the disease burden. So that developing countries face the triple burden of infectious disease, trauma and chronic disease. The causes of non-communicable diseases are smoking, obesity, physical inactivity and alcohol abuse – all lifestyle behaviours. The primary solution is disease prevention. In a statement adopted at this General Assembly in Uruguay last year the World Medical Association called for national policies that help people achieve healthy lifestyles and behaviors; for programs to increase access to primary care; for medical education systems to be socially accountable; to direct their education, research and service activities towards addressing the priority health concerns of the community, region or nation they serve; for strengthening the health care infrastructure to care for the increasing numbers of people with chronic disease. This includes: training the primary health care team; improved health care facilities such as hospitals and clinics; chronic disease surveillance; public health promotion campaigns; quality assurance; assuring adequate numbers of well-trained and motivated health care professionals.

This is a challenge that cannot be met solely by the individual physician seeing a patient in the office, important and essential as that is. It is a job for all of society – world governments, national medical associations, medical schools, patients and yes – individual physicians working in their communities seeking to affect health policy. But, lifestyle behaviours, smoking, obesity and alcohol abuse are only part of the story of NCDs.

To get there let me digress.

There is an old fable from this part of the world about three princes who lived long ago in the country of Serendippo – what we now know as Sri Lanka. Their father, the king, wanted them to have the best possible education. But even though he hired the very best teachers, he was not convinced that his sons were getting the training they needed to rule as king. So he sent them abroad, away from the privileges of the palace, to sharpen their wits and broaden their horizons. And in the course of their travels, by keeping their minds open, more by accident than design, they gained an education that afforded them the wisdom and knowledge to rule. And years later, the English writer Harold Walpole coined the word “serendipity” based on these stories. He noted that when the princes travelled, they were always making discoveries and developing the ability to link together seemingly unrelated facts to come to a valuable conclusion. Louis Pasteur, the French chemist and microbiologist, said it this way: “Chance favors the prepared mind.”

Our consideration of the proximate causes of non-communicable diseases – tobacco, obesity, alcohol – has led to the in some ways serendipitous understanding that there are equally important causes of the causes – root causes. These causes of the causes are social determinants of health – the conditions in which people are born, grow, live, work and age, and the societal influences on these conditions. They are major influences on both quality of life, including good health, and length of disability-free life. For example: in many societies, unhealthy behaviors are higher in people on the lower end of the social gradient. The lower they are in the socioeconomic hierarchy, the more they smoke, the worse their diet is and the less physical activity they engage in – thus, putting them at increased risk of non-communicable disease. Lower levels of education have the same effect – increased risk of non-communicable disease. Another example

is that price and availability are key drivers of alcohol consumption and smoking. The excellent scientific session we enjoyed yesterday asked the question Megacity – Megahealth?, illustrating another aspect of social determinants of health. We are indebted to the work of the Council member Sir Michael Marmot and his colleagues for giving understanding and international visibility to this important subject. For governments, understanding this concept means that all policies need to be evaluated as to their effects on the health of its citizens. Therefore, not just one designated minister of health, all ministers are health ministers. And the medical profession has a valuable role to play in seeking action on these social conditions, the causes of the causes that have such important effects on health.

My third point: global warming with its accompanying climate change, and its accompanying extremes of weather is already having and will continue to have significant health effects. Although governments and international organizations have the main responsibility for creating regulations and legislation to mitigate the effects of climate change the WMA feels an obligation to highlight the health consequences and suggest solutions. Over the past two decades extreme heat events have killed tens of thousands around the globe. Heat waves are becoming more frequent, of longer duration and more intense. Heat waves can cause illness and death from heart disease, diabetes, stroke, respiratory disease and even accidents, homicide and suicide. At the same time increased evaporation arising from warming seas is generating heavier downpours increasing flooding and water-borne disease outbreaks when flooding overwhelms sewer systems and contaminates drinking water. Warmer winters favor insect migration. In the past decade in the state of Maine in the US reports of tick-borne Lyme disease not only rose ten-fold but parts of the state experienced Lyme for the first time. Worldwide the ef-

fect may be mixed for Malaria. In some regions the geographical range will contract and in others expand, and the transmission season may be changed. Worldwide disruption of the food supply is predicted to increase malnutrition and subsequent disorders. Social and health inequalities due to possible desertification, natural disasters, changes in agriculture, feeding and water policy will have consequences on both human health and human resources in health and disproportionately affect developing countries.

Physicians have a role to play to: encourage advocacy for environmental protection, reduction of greenhouse gas production and sustainable development of green adaptation practices; work to improve the ability of patients to adapt to climate change and catastrophic weather events; work with others to educate the general public about the important effects of climate change on health and the need to mitigate climate change and adapt to its effects; work with others, including governments, to address the gaps in research regarding climate change and health. As individuals act to minimize their impact on the environment and to call all upon governments to strengthen public health systems in order to improve the capacity of communities to adapt to climate change. All of which brings to mind an ancient Chinese proverb: "When is the best time to plant a tree," asks a young student, sitting in the hot sun with his teacher. "Twenty years ago," replies the teacher. The young boy, feeling a drop of sweat run down his cheek asks, "Well, then when is the second best time?" "Now!!" intoned the teacher. Now. Now is the time.

Fifty years ago – doesn't seem that long – the US President John F. Kennedy gave a speech at Rice University in Houston. Kennedy spoke of the conquest not only of physical and technological barriers, but psychological ones. He said: "We choose to go to the moon in this decade and do the

other things, not because they are easy, but because they are hard. Because that goal will serve to organize and measure the best of our energies and skills. Because that challenge is one we are willing to accept, a challenge we are unwilling to postpone. And one we intend to win."

Ethics, non-communicable disease, climate change. So, is the job difficult? Yes.

Is the path long and winding? Absolutely. Is success assured? Absolutely not.

All the more reason to embrace it. And our success or lack of success depends in the end on our attitude.

The American industrialist Henry Ford said: "If you think you can, if you think you cannot, you are right." From India, Mahatma Gandhi said it this way: "Man often becomes what he believes himself to be. If I keep on saying to myself that I cannot do a certain thing, it is possible that I may end by really becoming incapable of doing it. On the contrary, if I have the belief that I can do it, I shall surely acquire the capacity to do it even if I may not have it at the beginning." As physicians, we are joined by our common contract with humanity. We reach out to the sick, the disabled and the chronically ill.

Suffering knows no language, and easing pain, finding treatments, developing cures – know no borders. Working together we can create the future of medicine. Together, we can open new doors, share new insights, find new cures, prevent disease and help our patients the world over to live healthier, happier, longer, more productive lives.

I look forward to that.

Thank you.

## Valedictory address

**José Luiz Gomes do Amaral,**  
President of the World Medical Association



*José Luiz Gomes do Amaral*

I will start by greeting and thanking you, all delegates from the medical associations, who gave me the privilege and the honor to represent the WMA. I thank the WMA Officers: the immediate Past President, Wonchat Subhachaturas, and all our former Presidents; the Chairman of the Council, my dear friend Mukesh Haik-erwal; the Vice-Chairman, Masami Ishi; our treasurer, Frank-Ullrich Montgomery; the Chairmen of our Standing Committees, Thorunn Jambu, Michael Marmot and Leonid Eidelman. All the members of the Council... Our always present Secretary General, the bright counselor and friend, Otmar Kloiber.

The friends we have in the extraordinary and competent WMA staff: Yoonsun "Sunny" Park, Roderik Dennett, Lamine Smaali, Clarice Delorme, Anne-Marie "Anna" Delage, Julia Seyer, Adolph Hallmayr and Annabel Seeböhm; Pēteris Apinis and Nigel Duncan. Also a very special warm greeting to Joelle Balfé. Our dear interpreters: thank you so much!

My dear Friends and Colleagues,  
I will talk about a long journey from Montevideo on the Atlantic Ocean to Bangkok, on the Pacific Ocean.

Since Montevideo (Uruguay), October 2011, I have faced an extensive agenda, which gave me the opportunity to experience the reality of medical practice, problems and accomplishments of many of the present day more than one hundred National Medical Associations that form our World Medical Association. Just after taking over the Office, our first commitment was to take part in the Social Determinants of Health at the International Conference in Rio de Janeiro (Brazil).

At that time, we talked about the importance of finding a solution for the social inequalities seen in both wealthy and developing countries. Those inequalities are the main factor responsible for the level of health of our populations. They refer to the conditions in which people are born and grow up, the differences in education, opportunities and working conditions, and to the conditions how people are ageing. There, we emphasized the importance of the role of Physicians in this field. In addition to assisting people in need, the profession includes interventions in the factors that cause poor health. In Chihuahua (Mexico), last November, we offered solidarity to our Mexican colleagues at the Assembly of the Mexican Medical College, where the issue was the response to violence against health professionals related to the drug trafficking war, particularly in the city of Juarez. There, I could see the many aspects of insecurity doctors face in many areas around the world. Several National Medical Associations from Latin-American Nations met on November 19 in Panama City (Panama). Among the

problems that threaten the quality of medical attention and, especially, Medicine, I observed the repeated political interferences in medical organizations, mainly in Bolivia and Venezuela. In Bolivia, the government tried to dismantle the medical profession and to regulate it themselves. They also decided on ethical issues and technical competences that qualify different specialties. The main goal of the Bolivian government is to fully control the profession.

Still in November, in Porto (Portugal), we met Portuguese medical students in order to discuss the European economic crisis viewed from the stand point of young doctors in a continent that is going through major challenges. This January and February, in São Paulo (Brazil), at the headquarters of the Medical Association of the State of São Paulo and in Rio de Janeiro (Brazil), we subscribed and announced the worldwide campaign for 2012 – "Global Appeal" against the discrimination faced by persons affected by leprosy, a neglected disease that still affects hundreds of thousands of people in different regions of the world.

One year after the earthquake followed by a tsunami and a nuclear accident in Japan, on March 11, 2012, we were in Tokyo (Japan) to discuss with our colleagues from the Japanese Medical Association about the WMA "Montevideo Declaration", which deals with the role of the medical associations and the physicians in response to disaster situations. The successful mobilization of Japanese physicians around that key issue gives us a picture of the enormous benefits of readiness in decreasing the impacts of catastrophic events less and less infrequent in people's lives.

In April this year, in Taipei (Taiwan), at the opening of the 20<sup>th</sup> International Conference on Health Promoting Hospitals, I addressed the role of hospitals and health services in the promotion of health and in tackling the social determinants of health. During that same event, we actively partici-

pated in the meeting “Health without Danger”, which was oriented to the management processes in health institutions and to environment preservation. More and more, the environmental impact of modern hospitals has been capturing the attention of society.

In Ankara and Istanbul (Turkey), also last April, WMA was represented by the President and by the Chairman of the Council for the mediation between physicians and a parliamentary group in that country in regard to a crisis caused by a decree which brutally restricted the independency and the authority of doctors for professional ethics and technical self-regulation. The increasing animosity of the Turkish government towards the medical profession created a hostile environment for health professionals, generating serious situations: Physicians were blamed for the consequences of the erroneous public system, and the dissemination of false information on the lack of doctors had been used as a justification to “import” physicians from neighbouring countries. The climax of the crisis was the murder of a 30-year-old doctor, followed by demonstrations all over the country. In Istanbul, as the president of WMA, I participated in a manifestation with more than 20 thousand doctors, bringing the city of Istanbul into a halt and raising a popular outcry as an extension of that tragedy.

On April 23<sup>rd</sup>, in London (England), Presidents of WMA and its Council took part in the meeting “Health Care in Danger”, an initiative that gathers organizations such as World and British Medical Associations, International Red Cross/Crescent and Doctors without Borders on the growing wave of violence against health professionals in civil and military conflicts in several regions of the world such as Somalia, Libya, Egypt, Bahrain, Syria, Iraq, Afghanistan, Israel, Mexico, Colombia. At that time, we presented the WMA’s position in the field of ethics and medical neutrality in situations of conflict. Physicians and other medical professionals have been arrested, kidnapped,

tortured and murdered in retaliation for assisting people that eventually belonged to an opposing group. Hospitals have been bombed and invaded. Such incidents have interrupted humanitarian actions, causing the withdrawal of voluntary teams to whom security cannot be provided, and leaving a great amount of unassisted people behind.

At the end of April, more precisely from the 24<sup>th</sup> to the 29<sup>th</sup>, many of us were together when the Council Meeting of the World Medical Association took place in Prague, the Czech Republic. In addition to the issues already mentioned before, other important ones such as the review of the Declaration of Helsinki were addressed.

In Geneva (Switzerland), this last May, at the WHO Assembly, we confirmed our partnership with WHPA and we discussed the economic crisis and health care. We hosted the traditional “WMA Luncheon”, which had the United States Secretary of Health and Human Services, the Honorable Kathleen Sybelius as a lecturer, and counting on the presence of Health Ministers from many countries. Last July, I took part in the Symposium “Healthcare systems in times of crisis – Protect the Present – Build the Future”: a debate in Lisbon (Portugal) with the Portuguese health authorities and Michael Porter from Harvard Business School about the quality of care and the opportunities in times of economic difficulties.

The value of a profession can be measured not only through the reputation of its members, the quality of the services they provide to their people, and their many contributions to Science, but also through their capacity to organize and support other organizations. I also had the privilege of attending the Assemblies of the German Medical Association, last May, in Nurnberg (Germany), the American Medical Association, last June in Chicago (United States), and, in Bournemouth (England), the British Medical Association Assembly. In each of those occasions, I could express to them our deep grati-

tude on behalf of the millions of doctors in the other 100 National Medical Associations which integrate the World Medical Association. In August, CONFEMEL gathered in Lima (Peru). This meeting gave me another opportunity to talk about the many reasons why they should strengthen the participation of Latin-American countries in WMA. In Madrid (Spain), last September, the main subject under discussion was medical attention to immigrants and the different regulations in several European countries. Finally, last September in Tiberias (Israel) on the Sea of Galilee, with Yoran Blachar and Leonid Eidelman, we discussed the possibilities of new partnerships with UNESCO in an educational program on medical ethics.

Dear Friends and Colleagues,

Before leaving, I would like to share with you a Guarani (South American Indian ethnic group) story: *Nhanderuvucu*, the Great Father, announced that the world would perish because of men’s iniquity, and ordered the sorcerer *Guiraypoty* to pray. The Earth was then got out of the ties that hung it in the sky and fire spread out, forcing *Guiraypoty* and his tribe to flee toward the East. They started a very long and hard journey, nowadays known as the *Peabiru* way, an ancient Indian route that linked the Pacific and the Atlantic Oceans, from Peru to São Paulo. They finally reached, at heaven’s door, the “*yvy marã ei*”, which means “a land without evilness”, a land with no suffering where people never get sick, old or die.

In 1947, just after the miseries of World War II, the millions of doctors represented herein started a long journey, crossing land and ocean. We have completed our path, our “*Peabiru*”, always praying for good standards in medical care, standing for human rights in health, and looking for a healthy land of equal opportunities, solidarity and justice.

Dear Cecil Wilson, now it is your turn to lead us and light our way.  
I am ready to follow you.  
Thank you very much.



## WMA General Assembly

63<sup>rd</sup> World Medical Association General Assembly, Bangkok, Thailand, October 2012

### Wednesday October 10

Delegates from more than 50 national medical associations met at the Centara Grand Hotel Convention Centre, Bangkok, Thailand for the 63<sup>rd</sup> annual General Assembly of the World Medical Association from October 10 to 13.

#### Council Session

The proceedings of the 192<sup>nd</sup> Council session were opened by Dr. Mukesh Haikerwal, Chair of the WMA, and delegates were welcomed by Dr. Wonchat Subhachaturas, President of the Medical Association of Thailand.

Dr. Haikerwal reported on recent events he had attended, including a meeting in Algiers of the Maghreb group of medical associations, including Tunisia, Morocco and Algeria. He said it was an important meeting to go to as the WMA had little presence in North Africa or the Gulf. It was a good meeting to start extending the spread of the WMA to organisations that were not part of the Association. The meeting also received an oral report from the Vice Chair of Council, Dr. Masami Ishii, who spoke about the cholera alert in the Middle East and the effect of pilgrims going to Saudi Arabia.

The President, Dr. José Luiz Gomes do Amaral, spoke about the many events he had attended around the world during the year, including the annual meetings of the German, American and British Medical Associations. At a meeting in Israel he had discussed the possibilities of a new partnership with UNESCO on an educational programme on medical ethics.

Dr. Otmar Kloiber, Secretary General, submitted a detailed written report from the secretariat to the Assembly about the general

activities of the Association. In his oral comments to Council he said that the WMA had been very successful in the last eight years in increasing the amount of financing for projects through sponsorship, but in the current financial crisis this was getting tougher. Funds were being restricted and more targeted. He thanked those organisations still sponsoring the Association, as well as national medical associations (NMAs) that had offered help to the WMA, either through advice, staff support or other activities. He said that for the first time the WMA had received sponsorship from the World Health Organisation for transforming one of the WMA's educational programmes on TB control into a more mobile device.

He also reported that grants were available through the World Health Professions Alliance for the counterfeit medicines campaign. Member organisations that combined together from different countries and different professions would be eligible to apply for a grant.

Two emergency motions were then presented to Council.

#### Minimum Unit Price for Alcohol

Dr. Vivienne Nathanson (British Medical Association) said that several legislatures, including Scotland, had either passed or were considering passing a law to enable them to set a minimum unit price for alcohol. It was believed this would make a significant difference to drinking levels. Unfortunately a number of governments, particularly within Europe, were trying to oppose the right of these governments to set a unit minimum price, saying it was a restraint on trade. In many countries, including the United Kingdom, there was a serious misuse of alcohol and the government was trying to take an evidence based public

health approach and was being stopped by other governments.

Council agreed that this was an urgent matter and should be considered by the Social Medical Affairs Committee.

#### Cigarette Packaging

Dr. Nathanson also presented an emergency motion on plain cigarette packaging and said this was about to come into force in Australia. But there were legal challenges from the tobacco industry. Many governments around the world were watching Australia and it was important that the profession showed that it supported all moves to reduce the consumption of tobacco.

Council again agreed that this was an urgent matter and should be considered by the Social Medical Affairs Committee.

The Council meeting was then suspended for the committee meetings to take place.

#### Medical Ethics Committee

The Medical Ethics Committee met with Dr. Torunn Janbu in the Chair.

#### Declaration of Helsinki

Dr. Ramin Parsa-Parsi, chair of the Workgroup on revising the Declaration, reported on progress. He spoke about preparations for two expert conferences in Cape Town, South Africa in December and in Tokyo, Japan in February. After these, the Workgroup would meet to consider a first draft of the revised Declaration to put to the Council meeting in April 2013. This would be followed by a public consultation until June.

Dr. Jeff Blackmer (Canada) summarised the comments received from 21 organisations, including eight NMAs, about what the main themes of the revision should be. These coalesced around insurance compensation and protection of research subjects, the use of unproven interventions, the issue of broad consent and medical research involving children.



The committee then received an oral report from the WMA's medical ethics adviser on the Declaration, Professor Urban Wiesing from the University of Tuebingen in Germany, about a first possible draft of paragraph 32 of the Declaration concerning the use of placebo control. He gave a history of previous changes to paragraph 32 and the criticisms that each change had provoked. He explained why the Workgroup was now proposing a more systematic approach.

In a brief debate that followed Dr. Peter Carmel (American Medical Association) congratulated Prof. Wiesing on his presentation. He said that the longer the Declaration was the more involved the explanations, the higher the number of exceptions that were included and the loss of precision

that was the basis of a universal statement. Dr. Jon Snaedal (Iceland) agreed that satisfactory progress was being made and the right balance was being struck.

Medical Ethics and Advanced Technology  
Revisions to the Declaration on Medical Ethics and Advanced Technology were debated and a discussion took place about whether the document should refer to 'patients' or 'persons'. It was decided to use the word 'persons' and to recommend forwarding the document to the Assembly for adoption.

### Safe Injections in Health Care

The committee considered a proposed revision of the 2002 WMA Statement on Safe Injections in Health Care and after several members proposed amendments it was

agreed that the document should be referred back to undergo further minor revision.

### Women's Right to Care

Dr. Mark Sonderup (South Africa) reported that the proposed Statement on Women's Right to Health Care and How that Relates to the Prevention of Mother-to-Child HIV Infection was in the process of being circulated to regional NMAs and a further report would be made to the next Council meeting in Bali in April 2013.

### Person Centred Medicine

Dr. Snaedal introduced a proposed Statement on Person Centred Medicine. He said NMAs had commented on the Statement, one suggesting that it should be divided in two, and another that the document was



*Wonchat Subhachaturas*



*Margaret Mungherera*



*Mukesh Haikerwal*



*Masami Ishii*



*Frank Ulrich  
Montgomery*



*Sir Michael Marmot*



*Leonid Eidelman*



*A. Hallmayr*



*Dongchun Shin*



*Torunn Janbu*



*Ramin Parsa-Parsi*



*Vivienne Nathanson*



*Sunny Park*



*Jeff Blackmer*



*Annabel Seebom*



*Anne-Marie Delage*



*Clarisse Delorme*



*Nigel Duncan*

too general in nature and needed to be more specific. Dr. Kloiber said that progress on this issue had been very interesting because the WMA had achieved bridging together two concepts, the patient centred approach that most NMAs had fostered for curative medicine and the more people centred approach of the WHO. The WHO had now joined with the WMA and others in trying to develop the debate and it was important that the WMA continued to be involved.

The committee agreed that the Statement needed further consideration before being recirculated among NMAs.

## Euthanasia

Dr. Janbu said that the WMA Resolution on Euthanasia was now 10 years old and should be reviewed. But there was also a Declaration on Euthanasia which was not subject to review at this time. The committee decided that the Resolution should undergo a minor revision by the secretariat.

## Death Penalty

Dr. Parsa-Parsi (Germany) presented a proposed Statement, jointly submitted by the German Medical Association, the Norwegian Medical Association and the French Conseil National de L'Ordre des Médecins, that the WMA should support a United Nations General Assembly Resolution calling for a moratorium on the use of the death penalty. He thanked the WMA Workgroup which had been set up to consider the ethical issues of capital punishment and had produced a paper. But it was not enough to simply ask physicians not to participate in capital punishment. The practice of the death penalty itself needed to be addressed. He acknowledged the different views and beliefs prevalent in the countries of NMA members, therefore the proposed Statement did not ask for a complete abolition of the death penalty, but rather a universal moratorium or a temporary suspension of the use of the death penalty by all states. There were many compelling reasons for supporting a moratorium. There was, for instance, no

conclusive evidence that the death penalty had any additional value as a deterrent. Also a miscarriage of justice could never be completely ruled out.

But several delegates from the USA spoke out against the proposal. Dr. Cecil Wilson, Chair of the Workgroup on capital punishment, said the group had already decided to recommend to the Assembly that as citizens physicians had the right to form their own views on capital punishment. He said there was a separation between what they did as physicians and what they might decide as non-physicians. Dr. Peter Carmel (American Medical Association) said it would be premature to circulate the new proposed Statement before the Assembly had considered the Statement from the Workgroup.

But Dr. Snaedal said that the moratorium proposal should be circulated because it was important that physicians addressed this issue. Dr. Nathanson also thought the issue should be circulated.

The committee agreed by 10 votes to four with two abstentions to recommend to Council that the proposal for a moratorium be circulated to NMAs.

## Human Rights

Clarisse Delorme, the WMA's Advocacy Advisor, reported on two current issues that had arisen since the written report on human rights had been submitted. The first related to Professor Cyril Karabus, a South African paediatrician, who was in jail in Abu Dhabi following his arrest on a charge of manslaughter relating to the death of a child under his care in the United Arab Emirates 10 years ago. The second concerned the health professionals who had been convicted and imprisoned in Bahrain on charges following a public demonstration. She told the committee that on both cases the WMA had taken action by writing to the respective authorities.

Dr. Mark Sonderup (South Africa) thanked the WMA for its assistance on Professor

Karabus, and said the South African Medical Association would like to submit an emergency motion later in the meeting.

## Clinical trials

Professor André Herchuelz (Belgium) raised the issue of a European Commission draft regulation that had been published in July regulating clinical trials in Europe. This had omitted all reference to prior approval by ethical committees which would have the effect of reducing the protection of patients. Dr. Kloiber said that the WMA was aware of the document, which he said was a legal document, and it was planning to submit a response shortly.

## Finance and Planning Committee

The Finance and Planning Committee met with Dr. Leonid Eidelman in the chair.

He opened the proceedings by saying that the WMA had had a sound financial year and had been able to fulfil its goals and still stay in a good financial position.

## Financial Statement

The committee considered and approved the audited financial statement for 2011 and agreed that it should be sent to Council and the Assembly for adoption.

## Budget for 2013

Mr Adi Hällmayr, the Financial Adviser, presented the proposed budget for 2013 and said the WMA had not had any exposure to financially risky investments. The policy was to protect the Association's assets. He explained the details of the Association's income and expenses. The Budget was adopted.

## Membership Dues

The committee received the report on membership dues payments for 2012 and Mr Hällmayr reported on dues arrears.

Dr. Kloiber spoke about the task of stabilising the dues, the baselines for payments and allowing some countries to pay by instal-





ments. The committee received the report, which was forwarded to the Assembly for information.

## Declaration of Helsinki 50<sup>th</sup> Anniversary

Dr. Eidelman, in his capacity as Chair of the Workgroup on the 50<sup>th</sup> anniversary of the Declaration of Helsinki, reported on plans for celebrating the anniversary in 2014. He said the goal should be to increase the visibility of the Declaration and strengthen the ownership of the WMA of the ethical principles on the experimentation on humans. Among the ideas being considered were the holding of a major event in Helsinki in 2014, simultaneous national and regional events around the world on World Medical Ethics Day in September 2014, articles by NMAs for the media, a survey of NMAs about the influence of the Declaration and a book on the history of the document.

## Strategic Plan 2013–2015

Dr. Robert Ouellet, Chair of the Workgroup on the Strategic Plan, gave a progress report on the strategic plan. He said the process which had been going on for some years had now reached its conclusion. NMAs had commented on the draft plan. A list of 38 strategic initiatives had been agreed and many were now being implemented.

Dr. Kloiber said that four themes of the plan had been identified as of particular importance – ethics, advocacy and representation; partnerships and collaboration; communication and outreach; and operational excellence. He detailed the plans for tackling 20 initiatives that had been highlighted for immediate action.

The committee agreed to forward the Plan to Council to be adopted by the Assembly.

## Business Development

Mr Tony Bourne, Chair of the Business Development Group, reported on progress in developing a WMA roundtable of commercial and non-commercial organisations who

wanted to develop a closer relationship with the Association. He said this would not be revenue producing, but it would be cost covering. The Group had developed draft terms of reference to govern the roundtable and had drawn up a short list of possible participants. These would be finalised and he said a report would be given to the next Council meeting in Bali in April 2013.

## Disaster Preparedness and Medical Response

Dr. Miguel Roberto Jorge, Chair of the Workgroup, gave an oral report on disaster preparedness, saying that a questionnaire based on the Declaration of Montevideo had been prepared for NMAs. This related to what initiatives should be undertaken. The summarised responses would be presented to the next Council meeting in Bali for further discussion.

## Future WMA Meetings

The committee considered arrangements for future WMA meetings. Invitations had been received from Argentina, Colombia, Taiwan and Russia to meet in their countries in 2015 and the committee heard presentations from Argentina, Taiwan and Russia. It recommended postponing any decision until the Council meeting in Bali.

## Greening of Meetings

The committee received an oral report from Dr. Mads Koch Hensen, Chair of the Workgroup on Greening of WMA meetings. He highlighted what had been done since the Council meeting in Sydney by way of reducing the use of paper at meetings, opening a new green page on the WMA website and assisting people to share airport transportation.

## Membership

A request was received from Romania for a change in membership. The committee recommended to Council that the Romanian Medical Association should be replaced by the Romanian College of Physicians.

## Relations with World Veterinary Association

The committee received a report on a proposed Memorandum of Understanding with the World Veterinary Association. Dr. Cecil Wilson said that one of the realities of the world was that whether their patients walked on two legs or four legs physicians and veterinarians shared two-thirds of all the world's diseases. It was therefore critical for the two professions to work together. The Memorandum of Understanding set out the principles under which the two organisations would co-operate.

## **Socio-Medical Affairs Committee**

The Socio-Medical Affairs Committee met with Sir Michael Marmot in the chair.

## Health and the Environment

Dr. Dongchun Shin (Korea) reported on a meeting of the Environment caucus earlier in the day. He said the meeting had discussed the outcome of the UN Conference on Sustainable Development and the outcome of the third session of the International Conference on Chemicals Management. In addition it had considered the promotion of green hospitals and sustainable transport. He said the NMAs were invited to share their experiences on the environment page of the WMA website.

## Social Determinants of Health

Sir Michael Marmot reported that the WMA and the International Federation of Medical Students had held a successful side event at the World Health Assembly where participants had discussed how physicians and medical students could get engaged in the issue of social determinants. Two NMAs, from Britain and Canada, had produced initiatives on this, preparing position statements on how doctors could get involved. He said it was planned to present a paper on this issue to the next meeting of Council.

## Health Care in Danger

Dr. Nathanson, Chair of the Workgroup on Health Care in Danger, reported on



how the group was supporting the campaign of the International Committee of the Red Cross on the issue of protecting health care in areas of armed conflict. The Workgroup had agreed to work on an ethics toolkit to mirror an ICRC publication on ethics law for doctors working in conflict situations. It would assist WMA speakers with slides for use in presentations and NMAs with advocacy materials. It had also agreed to work with the World Psychiatric Association on examining existing evidence on reducing violence in the health care workplace and it would monitor the WHO's activities.

## Ethical Implications of Physician Strikes

Leah Wapner (Israel) reported on the activities of the Workgroup on physician strikes. The Israeli Medical Association had put forward a proposed Statement on this issue at the last Council meeting. She presented a revised document, recognising that some NMAs did not have responsibility for trade union issues. But she said that at least half the NMA members were involved with negotiations and every NMA was involved in doctors' working conditions in some way or another. The proposed Statement had been revised to focus on the ethical principles that should be faced by NMAs and physicians once they had decided to engage in industrial action.

Dr. Janbu (Norway) thought the paper was still an unfortunate mix of ethical considerations and trade union issues. It also dealt with matters that were regulated by national laws. Dr. Jon Snaedal (Iceland) said this was a controversial document which should now be sent out for consideration by NMAs. But Dr. Frank Ulrich Montgomery (Germany) asked how a document such as this could be written without mixing up ethical and trade union issues. He thought this was a good document.

Dr. Konstanty Radzwill, President of the Standing Committee of European Doctors, also supported the Statement as a balanced document, which on the one hand showed

the responsibility of the profession and on the other hand reminded doctors to remember their patients when protesting.

Dr. Heikki Pälve (Finland) said doctors should have the right to strike, but they should not strike to achieve political goals. Physicians should carry out protest actions only to improve their working conditions and should not strike about patient care because that was for politicians to decide. The committee decided to recommend to Council that the document should be circulated for further consideration.

Ms Wapner said this was a matter of urgency because with so many NMAs taking strike action it was inconceivable that the WMA had no policy on the issue.

## Forced Sterilisations

Dr. Nathanson presented a proposed Statement on Forced and Coerced Sterilisation that had been submitted by the British Medical Association and had been circulated for comments. Several friendly amendments were suggested and agreed. The committee recommended that the Statement should be forwarded to Council for adoption by the Assembly.

## Prioritisation of Vaccination

Dr. Claire Camilleri (Irish Medical Association) presented a proposed Statement jointly with the Icelandic Medical Association. She said it was a reminder of the role of immunisation in global health. Smallpox had been eradicated and polio was on the verge of being eradicated. This Statement presented an opportunity to refocus attention onto the priority of delivering vaccination and immunisation programmes around the world.

The committee recommended that the Statement be forwarded to Council for adoption by the Assembly.

## Health Databases

Dr. Snaedal presented a proposed revision of the Declaration on Ethical Consider-

ations regarding Health Databases. He proposed that a Workgroup be established to further discuss the document and this was agreed by the committee.

## Political Abuse of Psychiatry

Dr. Jeremy Lazarus (American Medical Association) presented a proposed revision of the WMA Resolution on Political Abuse of Psychiatry. The document had been revised to add the use of psychiatric hospitals for religious persecution. It was agreed that this be forwarded to Council for adoption by the Assembly.

## Drugs and Methadone

A proposed Statement on drugs and methadone had been submitted by the National Medical Association of Kazakhstan. No-one from the association was present and after a brief debate, during which it was argued that the paper was contrary to scientific evidence and WMA policy, it was decided not to approve the paper.

## WMA Advocacy

Dr. Jeff Blackmer (Canada) reported on the activities of the Advocacy Advisory Committee and a survey that had been undertaken among NMAs. There had been a very good response rate showing a strong demand for training and workshops on advocacy. The Group suggested organising training sessions during a General Assembly and this topic could be the focus of a scientific session.

## Minimum Unit Price for Alcohol

The committee considered the emergency Resolution proposed earlier in the day. Dr. Nathanson said there was very clear evidence that if a minimum unit price was set as part of a strategy for dealing with alcohol abuse it influenced young people who were beginning to drink as well as older people with higher disposable incomes who were heavy drinkers. It reduced the average amount of alcohol consumed. Minimum unit pricing was part of a strategy that would include higher taxation and a ban on





advertising. The evidence from the UK was that a minimum unit price might reduce the level of drinking by between 10 and 25 per cent. But certain parts of the drinks industry had persuaded some governments to back them in opposing minimum unit pricing as a restraint of trade.

The committee agreed to forward the Resolution to Council for further discussion.

## Plain Packaging of Cigarettes

The committee also considered the emergency Resolution on plain packaging of cigarettes and it was agreed that this should be forwarded to Council for further discussion.

## *Thursday October 11*

### **Associates Members Meeting**

The meeting opened with Dr. Guy Dumont in the Chair. Dr. Xaviour Walker gave a report on the Junior Doctors Network, which had met earlier in the week. The Network had been busy during the year, producing a white paper on social media and medicine. It was now working on the issues of physician wellbeing and global health training and its ethical implications. Elections had been held at its meeting and the new Chair of the Network was Thorsten Hornung from Germany. It had represented the WMA at many meetings during the year.

### **Scientific Session 'MegaCity – MegaHealth'**

Dr. José Luiz Gomes do Amaral opened the proceedings by saying that cities generated between 30 and 50 per cent of the gross domestic product for their respective countries. But pollution, violence, traffic jams and traffic accidents, floods and poor infrastructure were common to most of them, affecting people's health. However big cities also contained big ideas and this was what speakers at the Scientific Session would be talking about.

Dr. Malinee Sukavejworakit, Deputy Governor of Bangkok, spoke about the goals of the Bangkok Metropolitan Administration to improve the health of its population. She said that with an inner city population of 5.7 million and an outer population of 10 million the city was faced with numerous health problems, including traffic congestion and accidents, poverty, social inclusion, noise pollution, crime, violence and mental health care. The goals were for Bangkok to become a healthy city where its residents had good health, good quality of life, happiness, safety, secure income, a pleasant environment for living with good governance and participation from all concerned. To that end the city had developed a 'Green and Clean' project that involved four development strategies – on shelter supply, social development and eradication of poverty, on progressive economic development, on good environmental management and on good governance.

She spoke about the city's response to last year's flood and the fact that no communicable diseases resulted from the event. The city was now putting in place measures to strengthen the city's flood defences.

Professor Yasuhide Nakamura, Professor of International Collaboration at Osaka University, said Tokyo Metropolitan City had a population of 13 million, 23 per cent of whom were 65 years old and over. United Nations statistics showed that the greater Tokyo area, including its neighbouring prefectures, was the biggest urban conglomeration in the world with a total population of 37.2 million.

He referred to the decline in the infant mortality rate in Tokyo and said that when the rate was high, fighting against starvation and infectious diseases were the main counter measures. Nowadays, improving the provision of psychosocial support for childrearing was one of the most critical issues because of the decrease in the number of children being born. In the city there were

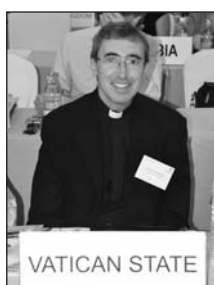
many programmes to improve maternal, neonatal, and child health, with the emphasis on the importance of starting childcare during pregnancy and continuing maternal health care after delivery.

He said the elderly population had also increased rapidly in the city, the majority being born in rural areas and moving to Tokyo for work during Japan's period of rapid economic growth. Most had chosen to stay and die in Tokyo, instead of returning to their hometowns. The characteristics of the "no return elderly" were very different from the elderly who had remained in rural areas. The "No return elderly" had relatively high levels of education and had often had business careers but they tended to lack social capital due to relatively weak family and community networks.

Finally, Professor Nakamura spoke about the city's disaster preparedness plans in the light of the earthquake and tsunami of 2011 and the lessons that had been learned. Several hundreds of the Japan Disaster Medical Assistance Team had provided emergency medical services just after the earthquake. Then, the Japan Medical Association, the Japanese Red Cross Society, and the Japan Primary Care Association, as well as municipalities and private hospitals gave their support.

He said that megacities had big advantages: a lot of human resources such as health professionals, universities and institutes conducting health research and highly advanced infrastructures. However, from the viewpoint of human resources, both strong leadership with regard to public protection and the empowerment of local communities were essential. The roles of frontline health workers became more important at the interface of protection and empowerment. The final target of health for everyone in a megacity was to entail a harmonious society, where people felt secure growing up, having children, working, growing old, and dying.







Dr. Bechara Choucair, Commissioner of the Chicago Department of Public Health, spoke about the Healthy Chicago public health agenda developed in 2011, which served as a framework for how the Chicago Department of Public Health was improving the health and well-being of all residents of the city. Healthy Chicago's development was guided by a commitment to implement policies, systems, and environmental changes to improve population health in partnership with the community. He highlighted a part of Chicago that many people did not see – with crowded housing, poverty, poorer education and health. Healthy Chicago was about making a difference in people's health – by identifying public health priorities, setting measurable targets for each of the priorities, identifying specific strategies around policy systems and environmental change, and finally finding more meaningful ways to engage community partners.

He gave a snapshot of various measures being taken. On tobacco he referred to the development of smoke free zones in the city, the prohibition of vending machines and the increase in fines for illegal cigarette sales. The city also faced a problem with obesity. Sixty per cent of the population was obese or overweight and 20 per cent of children entering kindergarten were obese. So the city was working with the public schools on a number of measures to tackle the problem. They were also providing neighbourhood fresh produce carts selling fresh food and vegetable. He spoke about the measures being taken on HIV Aids, leading to a significant decrease in the number of new cases in the city. He referred to disparities in breast cancer death rates between black and white women and about heart disease. Access to health care was also one of their priorities with half a million of the city's population having no access to health insurance.

The final speaker was Dr. José Bonamigo, from Brazil, an internist and haematologist practicing at the Albert Einstein Hospital in São Paulo.

He spoke about the Brazilian health system, particularly relating to São Paulo. He said the population of the city was 11 million people, with 20 million in the metro region. It was a very rich city. The national health system was mixed public and private created in 1990. There were three levels – the federal government, state level and city level. Seventy five per cent of the population depended on the public system with private health for those who had insurance. Sixty per cent of health expenditure was private and only 40 per cent public. In São Paulo 55 per cent of the population depended on public health, while 45 per cent had private insurance, much higher than the national average. While the older population was increasing, the younger population was shrinking.

He said the challenges facing the city included planning and managing demographic transition, improving access and improving primary care, which was the weakest part of the system. He also said there was a need to implement information technology projects so that health budgets could be better used.

He spoke in support of Brazil's public private partnership on health which had brought about an improvement in people's health. The old system was 100 per cent public health with huge underfunding. Under the new model, more money was being spent for clinical work with market rates being paid and the system was more transparent. In São Paulo the demand for doctors increased, as did the salaries.

## Friday October 12

### Council

Council met to consider the reports from its three committees and agreed to forward these to the Assembly for adoption. Further debates were held on the following:

### Declaration of Helsinki

It was agreed to hold an event in Helsinki to celebrate the 50<sup>th</sup> anniversary of the Declaration in 2014 and that a history of the document be published.

### Primary Health Care

Dr. Haikerwal reported on the idea of holding a global conference on primary health care. The idea was to hear about best practice models around the world and to discuss how the WMA might promote the best use of primary care physicians. It was proposed that a conference be held in the early part of 2013.

### Ethical Implications of Physician Strikes

Leah Wapner (Israel) proposed amendments to the proposed Statement that had already been discussed in the Socio-Medical Affairs Committee, adding the words 'Physicians carry out protest action and sanctions in order to improve direct and indirect working conditions which also may affect patient care'. She said the document did not state whether physicians should or should not take industrial action. It was ethical advice for when physicians decided to strike.

Dr. Eidelman proposed that the document should be forwarded to the Assembly for adoption rather than recirculated for further discussion.

But several delegates said that the Statement conflicted with the legislation in their countries. Dr. Janbu said that although the intention was good, the paper was not ready to be accepted as policy and she could not support it.

Dr. Lazarus said that it would be very hazardous for doctors in the USA to go on strike, but he thought the changed wording had improved the document as an ethical statement and he supported the idea of adoption. Dr. Montgomery said the fact was that physicians did take industrial action and the WMA had to give them ethical guidance. It was impossible to cover the legal situation in all 102 different states and he supported adopting the Statement.

Dr. Xaviour Walker said that junior doctors around the world faced very bad conditions, working with no employment contracts, very short maternity leave and unsafe working conditions. He therefore supported the Statement. Council agreed to recommend to the Assembly that the Statement should be adopted.

## Drugs and Methadone

Dr. Aizhan Sadykova (Kazakhstan) proposed a Statement on drugs and methadone. She said the doctors of Kazakhstan were united in the belief that drug addiction could not be treated by narcotics. She urged the WMA to support this position and to consider instead therapy that included preventive treatment, psychological and social rehabilitation of dependents.

Dr. Lazarus said the proposed Statement was contrary to existing WMA policy and contrary to 30 years research in the use of methadone as part of a treatment for addiction. Council agreed with the Socio-Medical Affairs Committee that the Statement should not be adopted. Council then considered the three emergency motions that had been proposed.

## Minimum Unit Price of Alcohol

Dr. Nathanson said this Resolution was about the right of a state to set a public health policy in place requiring legislation. A minimum unit price for alcohol was essential because countries like the UK, which had the second highest tax for alcohol anywhere in the world, had a major problem with alcohol. Simply increasing tax did not work. Minimum unit price was a method for saying that there was an amount below which nobody could sell alcohol. The alcohol industry was pressing a number of governments to support them in trying to stop in this case Scotland from enacting public health legislation. It seemed unacceptable that governments of other countries should be interfering with a public health measure by a government of a country with a serious public health crisis.

Dr. Lazarus proposed new wording that 'The WMA supports states seeking to use such innovative measures to combat the serious public and individual health effects of excessive and problem drinking.'

Council agreed to recommend the Resolution as amended to the Assembly for adoption.

## Plain Packaging of Cigarettes

Dr. Nathanson said the Australian legislation on plain packaging had passed but the tobacco industry was challenging the legal aspects of the changes. Several countries had said they would introduce such legislation if the Australian Government won the legal case. Doctors and the WMA should be seen to be supporting them.

Dr. Steve Hambleton (Australia) said the WMA should support the stand against tobacco companies. Big tobacco was now supporting individuals to take this issue to the World Trade Organisation. This emergency Resolution would give the Australian Government encouragement that they could make a stand.

Council agreed to recommend the Assembly to adopt the Resolution.

## Professor Cyril Karabus

Dr. Mark Sonderup (South Africa) proposed an emergency Resolution on the case of Professor Cyril Karabus. He said Prof. Karabus, a 78-year-old retired paediatric haematologist from South Africa, was working in the United Arab Emirates 10 years ago for a six week period. While there a child under his care died. Prof. Karabus returned to South Africa and unknown to him a charge was brought against him and in his absence he was found guilty of murder. This was never communicated to him and in August while he was travelling through Dubai he was arrested and jailed in Abu Dhabi. Despite six court appearances he was refused bail. The original murder charge was

dropped and this week he was granted bail to await his trial in November. Dr. Sonderup said they were extremely concerned about a number of issues and they were not convinced that Prof. Karabus would get access to a fair trial.

Dr. Kloiber thanked those NMAs who had raised this issue and urged other associations to take action. Council agreed to recommend the Assembly to adopt the Resolution.

## **Ceremonial Session**

The official opening of the 63<sup>rd</sup> General Assembly then took place. WMA President Dr. José Luiz Gomes do Amaral called the Assembly to order, before Dr. Kloiber introduced the delegations from the national medical associations and the observers of international organisations.

Delegates were welcomed by the guest of honour, Royal Privy Council, Prof. Dr. Kasem Wattanakul, and by Dr. Wonchat Subhachaturas, President of the Medical Association of Thailand.

Dr. Haikerwal, Chair of Council, paid tribute to the retiring President, Dr. Gomes do Amaral, who delivered a valedictory address.

Dr. Cecil Wilson was then installed as President of the WMA for 2012/13 and gave his inaugural address.

## ***Saturday October 13***

### **Assembly Plenary Session**

#### President Elect

Dr. Margaret Mungherera, President of the Uganda Medical Association, was elected unopposed as President-elect. Dr. Mungherera, a psychiatrist, will take up office in October 2013 and will serve for a year, becoming the first woman President of the

WMA since 2002 and the first African woman.

Dr. Mungherera thanked the Assembly for their support and said she had been a doctor for 30 years and a psychiatrist for 20 years with forensic psychiatry as her special area of interest. She had studied medicine at Makerere University Medical School in Kampala, Uganda, before taking a diploma in tropical medicine at the London School of Tropical Medicine and Hygiene. For the past 10 years she had been senior consultant psychiatrist at Mulago National Referral Hospital, Kampala. She was a founder member of Uganda Women Medical Doctors Association and was the first woman in Uganda to be elected President of the Uganda Medical Association in 1998 and again in 2010. She was in the forefront of bringing together the national medical associations in Eastern Africa (Kenya, Uganda, Tanzania and Rwanda) long before the revived East African Community started its work.

She said that one of her dreams was to get the poorer nations participating more in the WMA. She said she would like to see regular regional meetings so that the poorer and smaller member associations could gather together to discuss the many policies adopted by the WMA.

## Council Report

The Assembly received the report of the Council. Dr. Kloiber spoke about the year's activities and emphasised that the WMA was there to support NMAs if needed. He encouraged NMAs to consider applying for a grant related to the counterfeit medicine project and to consider nominating candidates to attend the next leadership course in January 2013.

## Advanced Technology

Dr. Haikerwal said that when there was a discussion on this topic earlier in the meeting it became clear there was little consideration of the positive role of health profes-

sionals in relation to the use of technology in the health care sector. As a result a paper would be drafted by Dr. Hambleton (Australia) for presentation at the next meeting.

## Ethical Implications of Collective Action by Physicians

A further lengthy debate took place about the wording of the document after Dr. Sonderup proposed an amendment to make it clear that 'Physicians may take part in individual acts or collective actions provided a minimum level of health care service is maintained.' This led to a discussion about the meaning of the word 'minimum', with delegates arguing that this could not be precisely defined. After several interventions, Dr. Hambleton said the document should simply read 'Physicians may carry out protest action.' This was eventually supported.

Several speakers then opposed the idea of opening the document with a negative sentence about physicians' dissatisfaction with their working conditions. This prompted a wider debate about whether the document should be recirculated among NMAs or adopted by the Assembly. On a vote, it was overwhelmingly decided against recirculating the document.

The meeting then voted to retain the opening sentence about physicians' working conditions, but agreed to amend it to read 'In recent years, in countries where physicians' satisfaction with their working conditions has decreased, collective action by physicians has become increasingly common.' Dr. Hambleton said it was important for the WMA to be seen to be providing leadership on this issue.

The amended Statement was finally adopted as WMA policy.

## Adopted Statements and Resolutions

The Assembly also adopted the following documents:

- Resolution on a Minimum Price for Alcohol

- Resolution on Plain Packaging of Cigarettes
- Resolution in Support of Professor Cyril Karabus
- Revised Declaration on Medical Ethics and Advanced Technology
- Statement on Organ Tissue and Donation
- Resolution on Physician Participation in Capital Punishment
- Revised Regulations in Times of Armed Conflict and Other Situations of Violence
- Statement on Electronic Cigarettes and Other Nicotine Delivery Systems
- Statement on Violence in the Health Sector by Patients and Those Close to Them
- Statement on Forced and Coerced Sterilisation
- Statement on the Prioritisation of Vaccination
- Resolution on the Abuse of Psychiatry

## Report of the Treasurer

Dr. Frank Ulrich Montgomery, the Treasurer, reported that net income had strengthened over recent years, although there had been a decrease in membership dues. He hoped that associations would pay their dues each year. He assured the Assembly that the money of the Association was safely invested and that the positive financial trend started in 2005 had been maintained.

The Assembly adopted the Financial Statement for the year ended 2011 and the Budget for 2013.

## Membership

The Assembly agreed that the Myanmar Medical Association and the Sri Lanka Medical Association be admitted into WMA membership, bringing the total number of NMA members to 102.

It was also agreed that the French Medical Association be replaced by the Conseil National de l'Ordre des Medecins and that the



Romanian Medical Association be replaced by the Romanian College of Physicians.

## Strategic Plan

The Strategic Plan 2013–15 was adopted.

## WMA Meetings

It was agreed that the 2014 Assembly take place in Durban, South Africa and that the decision about a venue for the 2015 meetings should be taken by the Executive Committee.

## World Dental Federation

In a presentation to the Assembly, Dr. Tin Chun Wong, President elect of the World Dental Federation, said that the FDI and the WMA had been working closely together through joint membership of World Health Professions Alliance. They had worked together on producing the toolkit for prevention of NCDs, first in paper form and now online. Both organisations should take immense pride in developing one of the few practical tools available on the market.

She then spoke about the FDI's new strategic plan, Vision 2020, which she described as a road map for the future of the dental profession. Its aim was to focus on emerging issues likely to impact the dental profession, such as areas of regulation, legislation and advocacy, and she added that if they did not do this other bodies would, notably politicians. The document provided a sketch of how oral health might look in 2020 and paved the way for a new model of oral health care. Vision 2020 was of extreme importance to dental profession and also to the partners of the WHPA. Dr. Wong said she trusted it would generate collaboration with other professions.

The document laid bare a number of issues, such as unequal access to oral health care around the world. In some parts of Europe there was one dentist for every 560 people and in some parts of the un-

der developed world that figure was 1 per 1.2 million. Even in a wealthy area such as California some two million people, eight per cent of the population, were missing hours of work and school because of dental diseases.

Dr. Wong said the document focused on a new model for oral health care which called for a move to a preventive approach.

## World Veterinary Association

A short ceremony was held for the WMA and the World Veterinary Association to sign a Memorandum of Understanding.

Dr. Cecil Wilson, President of the WMA, said the two professions shared much in common, whether on drug research, agriculture or nutrition. The interaction between the two professions was critical in treating and diagnosing. The Memorandum committed both organisations to the international movement, One Health Initiative, with the opportunity for continuing collaboration.

Dr. Faouzi Kechrid, President of the WVA, welcomed this new mutually beneficial relationship, which would allow both organisations to collaborate on improving global health and working on surveillance to prevent zoonotic disease.

## Associate Members

Dr. Xaviour Walker, outgoing Chair of the Junior Doctors Network, reported on the progress that the network had made over the past year. The Network was a platform for experience sharing and resource development and worked closely with the NMAs and with the International Federation of Medical Students Associations. The Network had held three meetings and he said it was important to keep contributing to WMA policies. The Network had produced the Social Media white paper, and were currently working on a review of physician wellbeing and global health training.

## Open Forum

An Open Meeting was then held, when NMAs and observers were invited to talk about any issue.

## Organ Transplants

Hernan Reyes, from the International Committee of the Red Cross, who said he had spent 22 years working with the WMA, congratulated the Assembly on adopting its document on organs transplants. But he said that there was no mention about living donors and the hidden issue of economic pressure where people felt under pressure to sell their kidneys for an iPad or a car. Although this was not allowed, there was a 'don't ask don't tell' tendency and some doctors were discreetly making a lot of money selling organs from so called relatives. He urged NMAs to be alert to these pressures and to ensure their physicians knew they should not accept organs unless they knew where they came from.

## Bahrain

Dr. Rudolph Henke (Germany), a delegate in the German Parliament, reported on his visit to Bahrain with a delegation from the German Parliament. They had met official representatives of the Royal Family, human rights activists and with four people who had received prison sentences. Those who had been jailed said that a number of doctors and nurses had been detained and abused, stripped of their clothes made to dance naked in front of their guards, beaten and subjected to other ill treatment. Other colleagues from academia and scientific circles had also been detained and some had been stripped of their licence and could no longer work. He said that after the demonstrations in the country the Royal Family had appointed a committee to examine these accusations. A 500-page report had now been published, answering the accusations levelled at government. Health professionals who had been jailed were more or less pardoned or reprieved. But recently there had been more arrests, trials and convictions. Some of these sentences, ranging

from imprisonment for a few months to several years, were still on appeal.

Dr. Henke said that those health professionals he had met were very grateful for the WMA support. He said he and his colleagues were planning to return next year to assess the situation and review progress.

### South East European Medical Forum

Dr. Andrey Kehayov, from the South East European Medical Forum, reported on the organisation's progress. It now had more than 15 members and was anxious to work closely with the WMA.

### Independence of Medical Associations

Dr. Konstanty Radzwill, from the Standing Committee of European Doctors, warned that they were facing in Europe attempts to standardise medicine and healthcare

from outside the profession. This was a real danger for physicians' autonomy and their patients. He said that with some support from parts of the medical profession there were bodies in Europe that were trying to standardise what doctors did. The Standing Committee was of the opinion that these issues should be done only by the profession and not by anyone outside.

Dr. Haikerwal referred to the independence of medical associations and problems that had occurred in Bolivia, Mexico, Slovakia, Poland and other countries, where the WMA had offered its support. He said he was particularly impressed at how the Turkish Medical Association had confronted their problems and had involved the WMA in helping them. He said this was an example that should be used as a template by other NMAs.

Dr. Ozdemir Aktar (Turkey) thanked the WMA for its help with the problems facing the Turkish Medical Association. The issues were still unresolved and were awaiting a decision of the Supreme Court. Last week a new report on Turkey was published, strongly criticising the country's record on freedom of speech, the number of people in jail and the pressure on certain organisations and unions, including the Turkish Medical Association. He said they were now faced with another problem, with 13 medical students who were in jail. These students had been in jail for four months, but did not know what they were accused of.

Dr. Kloiber said that the secretariat was in discussions with the Turkish Medical Association about future action.

## Secretary General's Report



Otmar Kloiber

Dr. Otmar Kloiber, Secretary General, presented the annual report of Council to the General Assembly, combined with his report from the secretariat. Among the significant activities during the year were:

### **Non-Communicable Diseases**

This was one of the most important topics on the public health agenda. The WMA had concerns from the beginning about the WHO's identification of four specific NCDs—namely, cardiovascular disease, cancer, lung and respiratory disease, and diabetes—as a focus of the NCD initiative. The risk of selecting particular diseases as a focus was a return to a silo-based approach to public health, similar to that of previous years when the focus was largely concentrated on HIV/AIDS, tuberculosis, malaria, and river blindness. The WMA advocated a comprehensive approach that linked individual risk factors with social and economic determinants of health, conditions in which people were born, grew up, lived, worked and aged, and the influences of society. The WMA emphasised the need to take a holistic approach, and suggested targets should address the elimination of

inequalities in health care. The WHO was currently developing a 2013–2020 Global Action Plan for the Prevention and Control of NCDs.

Together with the partners at the World Health Professions Alliance (WHPA), the WMA participated in the development of the NCD toolkit to assess the risk level in life style behaviours and bio measures in the form of NCD indicators. It was also setting up an independent project together with Sir Michael Marmot (British Medical Association) and his team to develop a common set of Social Determinants of Health and NCD indicators.

### **Multi Drug Resistant Tuberculosis Project**

In March, the WMA launched the revised MDR-TB online course. There was now a complete set of TB and MDR-TB courses as online versions, printed formats and CDs. The printed courses had been translated into Azeri, Chinese, French, Georgian,

Russian Spanish and other languages may follow. All courses could be accessed free of charge via the WMA webpage. The printed TB refresher course and the new MDR-TB course were nominated by the United States Centre for Disease Control (CDC) as an educational highlight and received an award.

The WMA was collaborating with the WHO to develop the MDR-TB course as an application for tablet computers, especially for low-cost 10-inch devices running on Android which were increasingly used in low-income countries. The app would be accessible from the WMA and WHO websites and, once downloaded, would be self-contained and able to run offline without an internet connection.

## Tobacco Project

The WMA was involved in the implementation process of the WHO Framework Convention on Tobacco Control and was co-operating with the public private partnership "QuitNowTXT" program to develop an evidence-based diffusion of health information for tobacco cessation via mobile phones to reach people at risk from preventable NCDs.

## Alcohol

The WMA was monitoring progress on the Global Strategy to Reduce the Harmful Use of Alcohol and was involved in conferences on the issues.

## Counterfeit Medical Products

The WMA and the members of the WHPA had stepped up their activities on counterfeit medical issues and developed an Anti-Counterfeit campaign with an educational grant from Pfizer Inc. and Eli Lilly. The basis of the campaign was the 'Be Aware' toolkit for health professionals and patients to increase awareness of this topic and provide practical advice for action to

take in case of a suspected counterfeit medical product. A grant application process for all national members was due to start from mid-October. All national members and national student organisations could apply for a grant of 2,500–5,000 US\$ for a half year project where at least two different health professional groups were involved. The deadline for applications was 30 November 2012.

## Health and the environment

### Climate change

The WMA had been involved in the UN Climate Change Conference in Durban in December 2011, and in an informal consultation group set up by the WHO which brought together civil society actors working on health and environmental issues. The WMA agreed to be a partner for the Global Climate and Health Summit and Prof. Dong Chun Shin (Korean Medical Association), represented the WMA at the Summit and presented the WMA Delhi Declaration on Health and Climate Change.

### Mercury

The WMA had been a member of the UNEP Global Mercury Partnership since December 2008 in order to contribute to the goal of protecting human health and the global environment from the release of mercury and its compounds. This engagement was based on the WMA Statement on Reducing the Global Burden of Mercury (Seoul, 2008). Together with the representatives of the Mercury Partnership, the WHO and other relevant health professionals, the WMA Secretariat was exploring the possibility of developing joint actions in this area.

### Chemicals

Since December 2009, the WMA had been engaged in the Strategic Approach to International Chemicals Management of the Chemicals Branch of the United Nations Environment Programme, which aimed to

develop a strategy for strengthening the engagement of the health sector in the implementation of the Strategic Approach. In consultation with the WHO, Prof. Shin had represented the WMA at several meetings.

In September 2012, the WMA, together with the World Federation of Public Health Associations, the Government of Slovenia and the WHO, organised a side event focussing on strengthening of the role of the health sector in international chemicals management. This event took place in the context of the third session of the International Conference on Chemicals Management, held in Nairobi in Sept. 2012. Participants looked at strategies while presenting examples of some recent innovations in multi-stakeholder engagement that promise a healthy outcome for all.

## Social Determinants of Health

The WMA attended as observer at the WHO World Conference on Social Determinants of Health in Rio de Janeiro in October 2011, which adopted a Declaration, emphasizing the role of the health sector in reducing health inequities. The WMA and the International Federation of Medical Students Associations held a side-event during the World Health Assembly in Geneva to discuss ways for health care providers to implement the Rio Declaration and engage in reducing health inequities.

## Health Care Systems

The World Economic Forum had organized a working group to develop and define the principles of a Global Charter on Health Data and the WMA represented the physicians' perspective in this group and had demanded the anonymity and aggregation of data, as well as patient ownership rights to the data. As the position of the WMA relating to patient advocacy had not been properly incorporated into this Charter, the WMA Executive Committee had not yet recommended signing it.



In June, the first ever Asia Pacific Influenza Summit took place in Bangkok, Thailand. Dr. Wonchat Subhachaturas was invited as past president of WMA to present a paper on the effect of influenza on health care workers. The aim of the conference was to increase awareness of the burden of influenza on public health in the Asia-Pacific region.

## Person Centred Medicine

Together with the World Psychiatric Association, the World Organization of Family Doctors, the World Health Organization, the International Association of Patient Organizations and many other partners, the WMA held the 4<sup>th</sup> Conference on Person Centered Medicine in Geneva in May 2012. The partners were currently preparing for the 5<sup>th</sup> Conference to be held from April 28-May 1 2013. Dr. Jon Snaedal represented the WMA.

## Positive Practice Environment Campaign

The WMA continued its close involvement with this campaign, spearheaded by WHPA members together with the International Hospital Federation, which aimed to ensure high-quality health workplaces for quality care. Activities on a country level continued in Uganda, Morocco and Zambia, which were among the fifty-seven countries worldwide suffering from a critical shortage of health care workers. The PPE Partners were working with national health professional and hospital organisations in these three countries to develop country projects and improve their practice environments.

## Migration & Retention

The WHO had developed the Guidelines on Retention Strategies for Health Professionals in Rural Areas, with the WMA taking part in the drafting process. The guidelines were based on three pillars: educational and regulatory incentives, monetary incen-

tives and management, and environment and social support.

## Workplace Violence in the Health Sector

The 3<sup>rd</sup> Conference on Workplace Violence in the Health Sector was due take place from 24–26 October 2012 in Vancouver. This was supported by the International Labour Organisation, the International Council of Nurses, Public Services International, the WHO and other health organizations. The WMA was a member of the planning committee.

## Education & Research

The World Federation for Medical Education had started a discussion process on the future role of the physician, involving the WMA, and international and regional organizations for medical education

The WMA had also participated as a member of steering groups in two projects commissioned by the European Union on the Mobility and Migration of Health Professionals.

## Patient Safety

The WHO had stepped up its commitment to patient safety and had revised the existing Patient Safety Curriculum Guide for medical schools and transformed it into a Multi-professional Patient Safety Curriculum Guide. The WMA was a member of the reviewing committee for the multi-professional guidelines

## Caring Physicians of the World Initiative

The fourth leadership course, organized by the INSEAD, was held at the INSEAD campus in Singapore from November 20–25 2011. The courses were made possible by an unrestricted educational grant provided by Pfizer, Inc. This work, including the prepa-

ration and evaluation of the course, was supported by the WMA cooperating centre, the Center for Global Health and Medical Diplomacy at the University of North Florida. The fifth course was planned, again at the INSEAD campus in Singapore, for early 2013.

## Health Politics

At the beginning of the year the, WMA intervened three times on health politics matters at the request of member associations:

In Slovakia, the government declared a state of emergency in hospitals in order to stop protests and industrial action by physicians fighting for better working conditions and against the privatisation of public hospitals. In consultation with the Slovak Medical Association, the WMA wrote to the Prime Minister and the President of the Republic to call for proper working conditions and fair payment.

In Poland, physicians were made liable for managing the reimbursement entitlements of the insured. Everyone in Poland was insured under a state insurance scheme which gave various entitlements for reimbursement. These different entitlements were at least in part non-transparent to the physicians, who should not be held liable for wrongly assigning reimbursement statuses for drugs on prescription. Together with the Polish Chamber of Physicians and Dentist, the WMA protested against this measure, which later was revoked.

At the end of last year, the Turkish Government removed key functions such as the supervision of physicians and the regulation of post-graduate education from the Turkish Medical Association and other self-governing institutions. Together with the Turkish Medical Association, the WMA staged public events in Ankara and Istanbul in April to fight for retaining these critical rights of physician self-governance.



## Social Media

The WMA Junior Doctors Network had developed a White Paper on Social Media and Medicine, helping to facilitate understanding of the mechanisms of social media, and giving guidance on the potential uses and risks of social media in medicine.

## Physicians and Patients in Distress Worldwide

### Bahrain

Since February 2011, the WMA had been monitoring the situation in Bahrain where assaults on health professionals by security forces had been reported by Amnesty International. Several appeals were sent to the Bahrain authorities expressing deep concern about access to appropriate healthcare for victims, as well as regarding the independence of health professionals. The WMA highlighted more specifically the case of 20 Bahraini health professionals who were sentenced by a military court last September to between five and 15 years in prison in connection with popular anti-government protests in February and March.

Last June, following the verdict of the High Criminal Court of Appeal regarding the 20 health professionals, the Secretariat sent another letter expressing concern for the 4 doctors Ali 'Esa Mansoor al-'Ekri, Ebrahim 'Abdullah Ebrahim, Ghassan Ahmed 'Ali Dhaif and Sa'eed Mothaher Habib Al Samahij for whom the court issued arrest orders.

### Egypt

In June, the WMA sent letters to the Egyptian authorities regarding the case of Mahmoud Mohamed Amin arrested by military forces near Al-Nour Mosque, Cairo in May 2012 because he had participated in a demonstration alongside hundreds of others to protest against military rule. He was then referred to the military prosecutor. According to Amnesty International, he already had a medical condition caused by military

forces and during his arrest was assaulted and injured and did not receive adequate medical care.

The WMA called upon the Egyptian authorities to allow Mahmoud Mohamed Amin to receive adequate medical care for his medical condition, and for his immediate and unconditional release.

### Iran

The Secretariat had acted in support of the Iranian blogger Hossein Ronaghi Maleki who was sentenced to 15 years in prison after a trial in 2010 for being a member of an illegal internet group, for spreading propaganda against the system and for insulting the leader and the President. The WMA called on the Iranian authorities to ensure that Mr Maleki received all necessary medical attention, including post-operative care as called for by his doctors and the Medical Examiner.

### Syria

The Association had issued press releases urging the Syrian authorities to call an immediate ceasefire to allow the sick and the wounded to be properly treated. The principle of neutrality was reiterated along with the Declaration of Tokyo, which clearly set out guidelines prohibiting physicians from participating in, or even being present during the practice of torture or other forms of cruel, inhuman or degrading procedures.

### Romania

In July 2012, the WMA responded at the request of the Romanian College of Physicians to interference by Romanian law enforcement agencies apparently violating the confidentiality of medical communication between physicians and their patients and relatives respectively. Following the attempted arrest of the previous president of Romania, who tried to commit suicide during the arrest and injured himself in the process, doctors were accused of being complicit in preventing the arrest by hospitalizing the injured person. The WMA

President wrote to the Romanian authorities demanding that they respect the confidentiality of medical communication and respect the rights of every patient, regardless of his or her civil status. The Romanian government responded with assurances of correct treatment.

## WHO Role in Humanitarian Emergencies

The growing threats to health personnel in armed conflicts areas and other situations of violence had been the subject of increasing global debate and action over the last year.

In January 2012, the WHO Executive Board discussed the role of the WHO as the health cluster lead in meeting the growing demands of health in humanitarian emergencies with a draft resolution for the Board's consideration. The Safeguarding Health in Conflict Coalition (composed of NGOs active in the field of health and/or humanitarian issues, including the WMA as an observer) sent an open letter for the attention of Member States in support of the draft resolution. The resolution was endorsed by the WHO Board, which recommended its adoption by the World Health Assembly in May.

Further to this resolution, the WHO organized a technical meeting in March, attended by the WMA, to discuss the methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies.

The resolution was finally adopted by the World Health Assembly in May. With the resolution, Member States called on WHO Director General: *"to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies, in coordination with other relevant United Nations*

*bodies, other relevant actors, and intergovernmental and nongovernmental organizations, avoiding duplication of efforts;"*

## ICRC Campaign "Health Care in Danger"

The WMA jointly organised a symposium entitled "The security and delivery of effective and impartial health care in armed conflict and other situations of violence" which took place in London in April 2012. Participants examined how to improve security and delivery of effective and impartial health care in armed conflict and other situations of violence, and provided the health community and other important stakeholders with an opportunity for greater engagement with this global humanitarian issue. Dr. José Luiz Gomes Do Amaral presented WMA policies related to this area.

## Cooperation with the International Rehabilitation Council for Torture Victims

As an elected member of the Executive Committee of the IRCT, Clarisse Delorme attended the meetings which took place in London last November, and in Copenhagen in September. Issues discussed included the preparations for the upcoming General Assembly (November 2012, Budapest), as well as the activities of the UN Subcommittee on Prevention of Torture and more generally the Human Rights Council.

## Detention

The WMA had been involved in the possible revision of the UN Standard Minimum Rules for the Treatment of Prisoners by the UN Office on Drugs and Crime, drawing the UN Office's attention to several relevant WMA policies on the conditions of prisoners from a medical ethics and human rights perspective.

In June, the WMA was invited by the UN Subcommittee on Prevention of Torture to participate in a roundtable discussion with NGOs on mental health issues in places of deprivation of liberty. The aim of the event was to enhance the Committee's skills and efficiency in preventing torture and ill-treatment in mental health institutions and to improve the situation of the mentally ill and the disabled by raising human rights standards and legal safeguards for this population.

## Women and Children, and Health

During the World Health Assembly, the WMA organised a reception for Ministers of Health and Heads of Delegations of the Assembly. The Honorable Kathleen Sebelius, the U.S. Secretary of Health and Human Services, was the key note speaker on the topic of Women's, Maternal and Girls' Health – Their Futures in Our Hands.

The WMA was an observer of the advocacy group of the mission of the Every Woman Every Child initiative, spearheaded by UN Secretary-General Ban Ki-moon, set up to mobilize and intensify global action to improve the health of women and children around the world.

The WMA had been involved in aiming to increase the health status of children, by developing with the German Development Aid Agency GIZ and the South East Asian Ministers of Education Organisation the 'Fit for School course'. This was designed to promote and facilitate effective school health programmes worldwide through building conceptual, implementation, and management capacity along with governments, international organisations and NGOs in low and middle-income countries. The course would be developed in a comprehensive yet modular way, enabling it to be adapted to different target audiences and national settings.

## The Declaration of Helsinki

In October 2011, the WMA Council decided to embark on a new process of revising the Declaration. A workgroup was formed with the mandate to present a revised wording of the Declaration to the Ethics Committee. The revision process was accompanied by a series of expert conferences to provide a platform for the international biomedical ethics community to air diverse viewpoints on the Declaration. The first conference was to be hosted by the South African Medical Association in Cape Town from 5–7 December 2012. This would be followed by a second conference hosted by the Japan Medical Association in Tokyo from February 28–March 1 2013.

The Workgroup aimed to gather as much input as possible from WMA members, the international expert community and relevant international organisations. A call for comments had been sent to all WMA members, and selected international organisations had been invited to submit their suggestions for topics requiring revision. A public consultation on the revision process was envisioned for spring 2013.

## World Health Professions Alliance

In May 2012, the fifth WHPA leadership forum discussed collaborative practice among health professionals and the implications of the financial crisis for national and international associations. As an outcome of the forum, the WHPA was developing a policy statement on collaborative practice focusing on the principle of collaborative practice with a global and universal approach.

## WMA Newsletter

The Secretariat has started a bi-monthly newsletter for its members. The first two issues were in July and September.



## WMA Declaration on Medical Ethics and Advanced Medical Technology

*Adopted by the 53<sup>rd</sup> WMA General Assembly, Washington, DC, USA, October 2002 and revised by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

It is essential to balance the benefits and risks for persons inherent in the development and application of advanced medical technology. Maintaining this balance is entrusted to the judgment of the physician.

Therefore:

Medical technology should be used to promote health. Patient safety should be fully considered by the physician in the development and application of medical technology.

In order to foster physicians' ability to provide appropriate medical care and having sufficient knowledge of medical technology efforts must be made to ensure the provision of comprehensive medical education focusing on the safe and effective use and development of medical technology.

## WMA Statement on Electronic Cigarettes and Other Electronic Nicotine Delivery Systems

*Adopted by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

### INTRODUCTION

electronic cigarettes (e-cigarettes) are products designed to deliver nicotine to a user in the form of a vapor. They are usually composed of a rechargeable battery-operated heating element, a replaceable cartridge that contains nicotine and/or other chemicals, and an atomizer that, when heated, turns the contents of the cartridge into a vapor (not smoke). This vapor is then inhaled by the user. These products are often made to look like other tobacco-derived products like cigarettes, cigars, and pipes. They can also be made to look like everyday items such as pens and USB memory sticks.

No standard definition of e-cigarettes exists and different manufacturers use different designs and different ingredients. Quality control

processes used to manufacture these products are substandard or non-existent. Few studies have been done to analyze the level of nicotine delivered to the user and the composition of the vapor produced.

Manufacturers and marketers of e-cigarettes often claim that use of their products is a safe alternative to smoking, particularly since they do not produce carcinogenic smoke. However, no studies have been conducted to determine that the vapor is not carcinogenic, and there are other potential risks associated with these devices: Appeal to children, especially when flavors like strawberry or chocolate are added to the cartridges. E-cigarettes can increase nicotine addiction among young people and their use may lead to experimenting with other tobacco products.

Manufacturers and distributors mislead people into believing these devices are acceptable alternatives to scientifically proven cessation techniques, thus delaying actual smoking cessation. E-cigarettes are not comparable to scientifically-proven methods of smoking cessation. Their dosage, manufacture, and ingredients are not consistent or clearly labelled. Brand stretching by using known cigarette logos is to be deplored.

Unknown amounts of nicotine are delivered to the user, and the level of absorption is unclear, leading to potentially toxic levels of nicotine in the system. These products may also contain other ingredients toxic to humans.

High potential of toxic exposure to nicotine by children, either by ingestion or dermal absorption, because the nicotine cartridges and refill liquid are readily available over the Internet and are not sold in child resistant packaging.

Due to the lack of rigorous chemical and animal studies, as well as clinical trials on commercially available e-cigarettes, neither their value as therapeutic aids for smoking cessation nor their safety as cigarette replacements is established. Lack of product testing does not permit the conclusion that e-cigarettes do not produce any harmful products even if they produce fewer dangerous substances than conventional cigarettes.

Clinical testing, large population studies and full analyses of e-cigarette ingredients and manufacturing processes need to be conducted before their safety, viability and impacts can be determined as either clinical tools or as widely available effective alternatives to tobacco use.

### RECOMMENDATIONS

That the manufacture and sale of e-cigarettes and other electronic nicotine delivery systems be subject to national regulatory bodies

prior approval based on testing and research as either a new form of tobacco product or as a drug delivery device.

That the marketing of e-cigarettes and other electronic nicotine delivery systems as a valid method for smoking cessation must be based on evidence and must be approved by appropriate regulatory bodies based on safety and efficacy data.

That e-cigarettes and other electronic nicotine delivery systems be included in smoke free laws.

Physicians should inform their patients of the risks of using e-cigarettes even if regulatory authorities have not taken a position on the efficacy and safety of these products.

## WMA Statement on the Ethical Implications of Collective Action by Physicians

*Adopted by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

### PREAMBLE

In recent years, in countries where physicians' satisfaction with their working conditions has decreased, collective action by physicians has become increasingly common.

Physicians may carry out protest action and sanctions in order to improve direct and indirect working conditions that also may affect patient care. Physicians must consider not only their duty to individual patients, but also their responsibility to improve the system such that it meets the requirements of accessibility and quality.

In addition to their professional obligations, physicians are often also employees. There may be tension between physicians' duty not to cause harm, and their rights as employees. Therefore, physicians' strikes or other forms of collective action often give rise to public debate on ethical and moral issues. This statement attempts to address these issues.

### RECOMMENDATIONS

The World Medical Association recommends that National Medical Associations (NMAs) adopt the following guidelines for physicians with regard to collective action:

Physicians who take part in collective action are not exempt from their ethical or professional obligations to patients.

Even when the action taken is not organized by or associated with the National Medical Association, the NMA should ensure that the individual physician is aware of and abides by his or her ethical obligations.

Whenever possible, physicians should press for reforms through non-violent public demonstrations, lobbying and publicity or informational campaigns or negotiation or mediation.

If involved in collective action, NMAs should act to minimize the harm to the public and ensure that essential and emergency health services, and the continuity of care, are provided throughout a strike. Further, NMAs should advocate for measures to review exceptional cases. If involved in collective action, NMAs should provide continuous and up-to-date information to their patients and the general public with regard to the demands of the conflict and the actions being undertaken. The general public must be kept informed in a timely manner about any strike actions and the restrictions they may have on health care.

## WMA Statement on Forced and Coerced Sterilisation

*Adopted by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

The WMA recognises that no person, regardless of gender, ethnicity, socio-economic status, medical condition or disability, should be subjected to forced or coerced permanent sterilisation.

A full range of contraceptive services, including sterilisation, should be accessible and affordable to every individual. The state may have a role to play in ensuring that such services are available, along with private, charitable and third sector organisations. The decision to undergo contraception, including sterilisation, must be the sole decision of the individual concerned.

As with all other medical treatments, sterilisation should only be performed on a competent patient after an informed choice has been made and the free and valid consent of the individual has been obtained. Where a patient is incompetent, a valid decision about treatment must be made in accordance with relevant legal requirements and the ethical standards of the WMA before the procedure is carried out. Sterilization of those unable to give consent would be extremely rare and done only with the consent of the surrogate decision maker.

Such consent should be obtained when the patient is not facing a medical emergency, or other major stressor.

The WMA condemns practices where a state or any other actor attempts to bypass ethical requirements necessary for obtaining free and valid consent.

Consent to sterilisation should be free from material or social incentives which might distort freedom of choice and should not be a condition of other medical care (including safe abortion), social, insurance, institutional or other benefits.

The WMA calls on national medical associations to advocate against forced and coerced sterilisation in their own countries and globally.

## WMA Regulations in Times of Armed Conflict and Other Situations of Violence

*Adopted by the 10<sup>th</sup> World Medical Assembly, Havana, Cuba, October 1956, and edited by the 11<sup>th</sup> World Medical Assembly, Istanbul, Turkey, October 1957, revised by the 35<sup>th</sup> World Medical Assembly, Venice, Italy, October 1983, the 55<sup>th</sup> WMA General Assembly, Tokyo, Japan, October 2004, editorially revised by the 173<sup>rd</sup> WMA Council Session, Divonne-les-Bains, France, May 2006, and revised by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

### General guidelines

Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics.

The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for physicians to:

- Give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable for the patient's health care;
- Weaken the physical or mental strength of a human being without therapeutic justification;
- Employ scientific knowledge to imperil health or destroy life;
- Employ personal health information to facilitate interrogation;
- Condone, facilitate or participate in the practice of torture or any form of cruel, inhuman or degrading treatment.

During times of armed conflict and other situations of violence, standard ethical norms apply, not only in regard to treatment but

also to all other interventions, such as research. Research involving experimentation on human subjects is strictly forbidden on all persons deprived of their liberty, especially civilian and military prisoners and the population of occupied countries.

The medical duty to treat people with humanity and respect applies to all patients. The physician must always give the necessary care impartially and without discrimination on the basis of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing or any other similar criterion.

Governments, armed forces and others in positions of power should comply with the Geneva Conventions to ensure that physicians and other health care professionals can provide care to everyone in need in situations of armed conflict and other situations of violence. This obligation includes a requirement to protect health care personnel and facilities.

Whatever the context, medical confidentiality must be preserved by the physician. However, in armed conflict or other situations of violence, and in peacetime, there may be circumstances in which a patient poses a significant risk to other people and physicians will need to weigh their obligation to the patient against their obligation to other individuals threatened.

Privileges and facilities afforded to physicians and other health care professionals in times of armed conflict and other situations of violence must never be used other than for health care purposes.

Physicians have a clear duty to care for the sick and injured. Physicians should recognise the special vulnerability of some groups, including women and children. Provision of such care should not be impeded or regarded as any kind of offence. Physicians must never be prosecuted or punished for complying with any of their ethical obligations.

Physicians have a duty to press governments and other authorities for the provision of the infrastructure that is a prerequisite to health, including potable water, adequate food and shelter.

Where conflict appears to be imminent and inevitable, physicians should, as far as they are able, ensure that authorities are planning for the protection of the public health infrastructure and for any necessary repair in the immediate post-conflict period.

In emergencies, physicians are required to render immediate attention to the best of their ability. Whether civilian or combatant, the sick and wounded must receive promptly the care they need. No distinction shall be made between patients except those based upon clinical need.



Physicians must be granted access to patients, medical facilities and equipment and the protection needed to carry out their professional activities freely. Such access must include patients in detention centres and prisons. Necessary assistance, including unimpeded passage and complete professional independence, must be granted.

In fulfilling their duties and where they have the legal right, physicians and other health care professionals shall be identified and protected by internationally recognized symbols such as the Red Cross, Red Crescent or Red Crystal.

Hospitals and health care facilities situated in areas where there is either armed conflict or other situations of violence must be respected by all combatants and media personnel. Health care given to the sick and wounded, civilians or combatants, cannot be used for publicity or propaganda. The privacy of the sick, wounded and dead must always be respected. This includes visits from important political figures for media purposes and also when important political figures are among the wounded and the sick.

Physicians must be aware that, during armed conflict or other situations of violence, health care becomes increasingly susceptible to unscrupulous practice and the distribution of poor quality/counterfeit materials and medicines, and attempt to take action on such practices.

The WMA supports the collection and dissemination of data related to assaults on physicians, other health care personnel and medical facilities, by an international body. Such data are important to understand the nature of such attacks and to set up mechanisms to prevent them. Assaults against medical personnel must be investigated and those responsible must be brought to justice.

## **Code of conduct: duties of physicians working in armed conflict and other situations of violence**

Physicians must in all circumstances:

- Neither commit nor assist violations of international law (international humanitarian law or human rights law);
- Not abandon the wounded and sick;
- Not take part in any act of hostility;
- Remind authorities of their obligation to search for the wounded and sick and to ensure access to health care without unfair discrimination;
- Advocate and provide effective and impartial care to the wounded and sick (without reference to any ground of unfair discrimination, including whether they are the “enemy”);
- Recognise that security of individuals, patients and institutions are a major constraint to ethical behaviour and not take undue risk in the discharge of their duties;

- Respect the individual wounded or sick person, his/her will, confidence and his/her dignity;
- Not take advantage of the situation and the vulnerability of the wounded and sick for personal financial gain;
- Not undertake any kind of experimentation on the wounded and sick without their real and valid consent and never where they are deprived of liberty;
- Give special consideration to the greater vulnerability of women and children in armed conflict and other situations of violence and to their specific health-care needs;
- Respect the right of a family to know the fate and whereabouts of a missing family member whether or not that person is dead or receiving health care;
- Provide health care for anyone taken prisoner;
- Advocate for regular visits to prisons and prisoners by physicians, if such a mechanism is not already in place;
- Denounce and act, where possible, to put an end to any unscrupulous practices or distribution of poor quality/counterfeit materials and medicines;
- Encourage authorities to recognise their obligations under international humanitarian law and other pertinent bodies of international law with respect to protection of health care personnel and infrastructure in armed conflict and other situations of violence;
- Be aware of the legal obligations to report to authorities the outbreak of any notifiable disease or trauma;
- Do anything within their power to prevent reprisals against the wounded and sick or health care;
- Recognise that there are other situations where health care might be compromised but in which there are dilemmas.

Physicians should to the degree possible:

- Refuse to obey an illegal or unethical order;
- Give careful consideration to any dual loyalties that the physician may be bound by and discuss these dual loyalties with colleagues and anyone in authority;
- As an exception to professional confidentiality, and in line with WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment and the Istanbul Protocol<sup>1</sup>, denounce acts of torture or cruel, inhuman or degrading treatment of which physicians are aware, where possible with the subject's consent, but in certain circumstances where the victim is unable to express him/herself freely, without explicit consent;
- Listen to and respect the opinions of colleagues;
- Reflect on and try to improve the standards of care appropriate to the situation;

<sup>1</sup> Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, OHCHR, 1999

- Report unethical behaviour of a colleague to the appropriate superior;
- Keep adequate health care records;
- Support sustainability of civilian health care disrupted by the context;
- Report to a commander or to other appropriate authorities if health care needs are not met;
- Give consideration to how health care personnel might shorten or mitigate the effects of the violence in question, for example by reacting to violations of international humanitarian law or human rights law.

## WMA Statement on Organ and Tissue Donation

*Adopted by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

### PREAMBLE

Advances in medical sciences, especially surgical techniques, tissue typing and immuno-suppressive drugs, have made possible a significant increase in the rates of successful transplantation of human organs and tissue. Yet, in all countries, a shortage of organ donors results in potentially avoidable loss of life. National medical associations should support attempts to maximise the number of donor organs available in their countries and to ensure that the highest ethical standards are maintained. The World Medical Association has developed this policy to assist medical associations, physicians, other health care providers and policy makers to achieve this.

- This policy is based on a number of core principles: altruism, autonomy, beneficence, equity and justice. These principles should guide those developing local policies and those operating within it, both in relation to organ procurement and to the distribution and transplantation of donor organs. All systems and processes should be transparent and open to scrutiny.
- This statement applies to organ and tissue donation from both deceased and living donors. It does not apply to blood donation.

### Raising public awareness

It is important that individuals are aware of the option of donation and have the opportunity to choose whether or not to donate organs and/or tissue after their death. Awareness and choice should be facilitated in a coordinated multi-faceted approach by a variety of stakeholders and means, including media awareness and public campaigns. In designing such campaigns account

needs to be taken of any religious or cultural sensitivities of the target audience.

Through awareness raising campaigns, individuals should be informed of the benefits of transplantation, the impact on the lives of those who are waiting for a transplant and the shortage of donors available. They should be encouraged to think about their own wishes about donation, to discuss their wishes with their family and friends and to use established mechanisms to formally record them by opting into, or out of, donation.

The WMA advocates informed donor choice. National medical associations in countries that have adopted or are considering a policy of “presumed consent” (or opt-out), in which there is an assumption that the individual wishes to donate unless there is evidence to the contrary, or “mandated choice”, in which all persons would be required to declare whether they wish to donate, should make every effort to ensure that these policies have been adequately publicised and do not diminish informed donor choice, including the patient’s right not to donate.

Consideration should be given to the establishment of national donor registries to collect and maintain a list of citizens who have chosen either to donate or not to donate their organs and/or tissue. Any such registry must protect individual privacy and the individual’s ability to control the collection, use, disclosure of, and access to, his or her health information for other purposes. Provisions must be in place to ensure that the decision to sign up to a register is adequately informed and that registrants can withdraw from the registry easily and quickly and without prejudice.

Living organ donation is becoming an increasingly important component of transplantation programmes in many countries. Most living donation is between related or emotionally close individuals but small but increasing numbers are donating to people they do not know. Given that there are health risks associated with living organ donation, proper controls and safeguards are essential. Information aimed at informing people about the possibility of donating organs as a living donor should be carefully designed so as not to put pressure on them to donate. Potential donors should know where to obtain detailed information about what is involved, should be informed of the inherent risks and should know that there are safeguard in place to protect those offering to donate.

### Protocols for organ and tissue donation from deceased donors

The WMA encourages its members to support the development of comprehensive, coordinated national protocols for deceased (also referred to as cadaveric) organ and tissue procurement in consulta-

tion and cooperation with all relevant stakeholders. Ethical, cultural and societal issues arising in connection with donation and transplantation should be resolved, wherever possible, in an open process involving public debate informed by sound evidence.

National and local protocols should provide detailed information about the identification, referral and management of potential donors as well as communication with those close to people who have died. They should encourage the procurement of organs and tissues consistent with this statement. Protocols should uphold the following key principles:

- Decisions to withhold or withdraw life-prolonging treatment should be based on an assessment of whether the treatment is able to benefit the patient. Such decisions must be, and must be seen to be, completely separate from any decisions about donation
- The diagnosis of death should be made according to national guidelines and as outlined in the WMA's Declaration of Sydney on the Determination of Death and Recovery of Organs.
- There should be a clear separation between the treating team and the transplant team. In particular, the physician who declares or certifies the death of a potential donor should not be involved in the transplantation procedure. Nor should he/she be responsible for the care of the organ recipient.
- Countries that carry out donation following circulatory death should have specific and detailed protocols for this practice.
- Where an individual has expressed a clear and voluntary wish to donate organs and/or tissue after death, steps should be taken to facilitate that wish wherever possible. This is part of the treating team's responsibility to the dying patient.
- The WMA considers that the potential donor's wishes are paramount. Relatives and those close to the patient should be strongly encouraged to support a deceased person's previously expressed wish to donate organs and/or tissues.
- Those charged with approaching the patient, family members or other designated decision maker about organ and tissue donation should possess the appropriate combination of knowledge, skill and sensitivity for engaging in such discussions. Medical students and practising physicians should seek the necessary training for this task, and the appropriate authorities should provide the resources necessary to secure that training.
- Donation should be unconditional. In exceptional cases, requests by potential donors, or their substitute decision makers, for the organ or tissue to be given to a particular recipient may be considered if permitted by national law. Donors seeking to apply conditions that could be seen as discriminatory against certain groups, however, should be declined.

Hospitals and other institutions where donation occurs should ensure that donation protocols are publicised amongst those likely to use them and that adequate resources are available for their imple-

mentation. They should also foster a pro-donation culture within the institution in which consideration of donation is the norm, rather than the exception, when a patient dies.

The role of transplant coordination is critical to organ donation. Those performing coordination act as the key point of contact between the bereaved family and the donation team and usually also undertake the complex logistical arrangements to make donation happen. Their role should be recognised and supported.

Deceased organ donation must be based on the notion of a gift, freely and voluntarily given. It should involve the voluntary and unpressured consent of the individual provided before death (by opting in or opting out of donation depending upon the jurisdiction) or the voluntary authorisation of those close to the deceased patient if that person's wishes are unknown. The WMA is strongly opposed to the commercialisation of donation and transplantation.

Prospective donors or their substitute health care decision makers<sup>1</sup> should have access to accurate and relevant information, including through their general practitioners. Normally, this will include information about:

- the procedures and definitions involved in the determination of death,
- the testing that is undertaken to determine the suitability of the organs and/or tissue for transplantation and that this may reveal previously unsuspected health risks in prospective donors and their families,
- measures that may be required to preserve organ function until death is determined and transplantation can occur,
- what will happen to the body once death has been declared,
- what organs and tissues can be donated,
- the protocol that will be followed in the event that the family objects to donation, and
- the possibility of withdrawing consent.

Prospective donors or their substitute health care decision makers should be given the opportunity to ask questions about donation and should have their questions answered sensitively and intelligibly.

Where both organs and tissues are to be donated, information should be provided, and consent obtained, for both together in order to minimise distress and disruption to those close to the deceased.

In some parts of the world a contribution towards funeral costs is given to the family of those who donate. This can be viewed either

<sup>1</sup> The term "substitute health care decision maker" is intended to refer to any person properly designated to make health care related decisions on behalf of the patient.



as appropriate recognition of their altruistic act or as a payment that compromises the voluntariness of the choice and the altruistic basis for donation. The interpretation may depend, in part, on the way it is set up and managed. When considering the introduction of such a system, care needs to be taken to ensure that the core principles of altruism, autonomy, beneficence, equity and justice are met.

Free and informed decision making requires not only the provision of information but also the absence of coercion. Any concerns about pressure or coercion should be resolved before the decision to donate organs or tissue is made.

Prisoners and other people who are effectively detained in institutions should be eligible to donate after death only in exceptional circumstances where:

- there is evidence that this represents their long-standing and considered wish and safeguards are in place to confirm this; and
- their death is from natural causes; and
- the organs are donated to a first or second degree relative either directly or through a properly regulated pool.

In jurisdictions where the death penalty is practised, executed prisoners must not be considered as organ and/or tissue donors. While there may be individual cases where prisoners are acting voluntarily and free from pressure, it is impossible to put in place adequate safeguards to protect against coercion in all cases.

## Allocation of organs from deceased donors

The WMA considers there should be explicit policies, open to public scrutiny, governing all aspects of organ and tissue donation and transplantation, including the management of waiting lists for organs to ensure fair and appropriate access.

Policies governing the management of waiting lists should ensure efficiency and fairness. Criteria that should be considered in allocating organs or tissue include:

- severity and urgency of medical need
- length of time on the waiting list
- medical probability of success measured by such factors as age, type of disease, likely improvements in quality of life, other complications, and histocompatibility.

There should be no discrimination based on social status, lifestyle or behaviour. Non-medical criteria should not be considered.

Living donation is becoming increasingly common as a way to overcome the shortage of organs from deceased donors. In most cases donors provide organs to relatives or people to whom they are emo-

tionally close. A small number of individuals choose to donate an organ altruistically to a stranger. Another scenario is where one or more donor and recipient pairs are incompatible with each other but donate in the form of a cross-over or pooled donation system (for example, donor A donates to recipient B, donor B donates to recipient C and donor C donates to recipient A).

All potential donors should be given accurate and up to date information about the procedure and the risks of donation and have the opportunity to discuss the issue privately with a member of the healthcare team or a counsellor. Normally this information will include:

- the risks of becoming a living donor,
- the tests that are undertaken to assess suitability for donation and that this may reveal previously unsuspected health problems,
- what will happen before, during and after donation takes place, and
- in the case of solid organs, the long-term implications of living without the donated organ.

Prospective donors should be given the opportunity to ask questions about donation and should have their questions answered sensitively and intelligibly.

Procedures should be in place to ensure that living donors are acting voluntarily and free from pressure or coercion. In order to avoid donors being paid and then posing as a known donor, independent checks should also be undertaken to verify the claimed relationship and, where this cannot be proven, the donation should not proceed. Such checks should be independent of the transplant team and those who are caring for the potential recipient.

Additional safeguards should be in place for vulnerable donors, including but not only, people who are dependent in some way (such as competent minors donating to a parent or sibling).

Prisoners should be eligible to be living donors only in exceptional circumstances, to first or second degree family members; evidence should be provided of any claimed relationship before the donation may proceed. Where prisoners are to be considered as living donors, extra safeguards are required to ensure they are acting voluntarily and are not subject to coercion.

Those who lack the capacity to consent should not be considered as living organ donors because of their inability to understand and decide voluntarily. Exceptions may be made in very limited circumstances, following legal and ethical review.

Donors should not lose out financially as a result of their donation and so should be reimbursed for general and medical expenses and

any loss of earnings incurred. In some parts of the world individuals are paid for donating a kidney, although in virtually all countries the sale of organs is unlawful. The WMA is opposed to a market in organs.

Protocols for free and informed decision making should be followed in the case of recipients of organs or tissue. Normally, this will include providing information about:

- the risks of the procedure,
- the likely short, medium and long-term survival, morbidity, and quality-of-life prospects,
- alternatives to transplantation, and
- how organs and tissues are obtained.

Organs or tissue suspected to have been obtained through unlawful means must not be accepted for transplantation

Organs and tissues must not be sold for profit. In calculating the cost of transplantation, charges related to the organ or tissue itself should be restricted to those costs directly associated with its retrieval, storage, allocation and transplantation.

Transplant surgeons should seek to ensure that the organs and tissues they transplant have been obtained in accordance with the provisions of this policy and should refrain from transplanting organs and tissues that they know, or suspect, have not been procured in a legal and ethical manner.

In the case of a delayed diagnosis for infection, disease or malignancy in the donor, there should be a strong presumption that the recipient will be informed of any risk to which they may have been exposed. Individual decisions about disclosure need to take account of the particular circumstances, including the level and severity of risk. In most cases disclosure will be appropriate and should be managed carefully and sensitively.

## FUTURE OPTIONS

Public health measures to reduce the demand for donated organs should be seen as a priority, alongside moves to increase the effectiveness and success of organ donation systems.

New developments and possibilities, such as xenotransplantation and the use of stem cell technology to repair damaged organs, should be monitored. Before their introduction into clinical practice such technologies should be subject to scientific review and robust safety checks as well as ethical review. Where, as with xenotransplantation, there are potential risks that go beyond individual recipients, this process should also involve public debate.

## WMA Statement on the Prioritisation of Immunisation

*Adopted by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

### PREAMBLE

Vaccination use to prevent against disease was first done successfully by Jenner in 1796 when he used cowpox material for vaccination against smallpox. Since then, vaccination and immunisation have been acknowledged as an effective preventive strategy for several communicable diseases and are now being developed for the control of some non-communicable diseases.

Vaccine development and administration are some of the most significant interventions to influence global health in modern times. It is estimated that immunisation currently prevents approximately 2.5 million deaths every year, saving lives from diseases such as diphtheria, tetanus, whooping cough (pertussis) and measles. Approximately 109 million children under the age of one are fully vaccinated with the diphtheria-tetanus-pertussis (DTP3) vaccine alone.

Mostly the ultimate goal of immunisation is the total eradication of a communicable disease. This was achieved for smallpox in 1980 and there is a realistic goal for the eradication of polio within the next few years.

The Global Immunisation Vision Strategy (GIVS) 2006–2015 was developed by the WHO and UNICEF in the hope of reaching target populations who currently do not have immunisation services or who do not have an adequate level of coverage.

The four strategies promoted in this vision are:

- Protecting more people in a changing world
- Introducing new vaccines and technologies
- Integrating immunisation, other linked health interventions and
- Surveillance in the health systems context
- Immunizing in the context of global interdependence<sup>1</sup>

<sup>1</sup> World Health Organization and United Nations Children's Fund. Global Immunisation Vision and Strategy, 2006–2015. Geneva, Switzerland: World Health Organization and United Nations Children's Fund; 2005. Available at: [http://www.who.int/immunisation/givs/related\\_docs/en/index.html](http://www.who.int/immunisation/givs/related_docs/en/index.html)

Vaccine research is constantly revealing new possibilities to protect populations from serious health threats. Additionally, new strains of diseases emerge requiring the adaptation of vaccines in order to offer protection.

The process of immunisation requires an environment that is resourced with appropriate materials and health workers to ensure the safe and effective administration of vaccines. Administration of vaccines often requires injections, and safety procedures for injections must always be followed.

Immunisation schedules can vary according to the type of vaccine, with some requiring multiple administrations to be effective. It is vitally important that the full schedule is followed otherwise the effectiveness of the vaccine may be compromised.

The benefits of immunisation have had a profound effect on populations, not only in terms of preventing ill health but also in permitting resources previously required to treat the diseases to be redirected to other health priorities. Healthier populations are economically beneficial and can contribute more to society.

Reducing child mortality is the fourth of the United Nation's Millennium Development Goals, with immunisation of children having a significant impact on mortality rates on children aged under five. According to the WHO, there are still more than 19 million children who have not received the DTP3 vaccine. In addition, basic health care services for maternal health with qualified health care personnel must be established.

Immunisation of adults for diseases such as influenza and pneumococcal infections has been shown to be effective, not only in decreasing the number of cases amongst those that have received immunisation but also in decreasing the disease burden in society.

The medical profession denounce any claims that are unfounded and inaccurate with respect to the possible dangers of vaccine administration. Claims such as these have resulted in diminished immunisation rates in some countries. The result is that the incidences of the diseases to be prevented have increased with serious consequences for a number of persons.

Countries differ in immunisation priorities, with the prevalence and risk of diseases varying among populations. Not all countries have the same coverage rates, nor do they have the resources to acquire, coordinate, distribute or effectively administer vaccines to their populations, often relying on non-governmental organizations to support immunisation programmes. These organizations in turn often rely on external funding that may not be secure. In times of

global financial crisis, funding for such programmes is under considerable pressure.

The risk of health complications from vaccine-preventable diseases is greatest in those who experience barriers in accessing immunisation services. These barriers could be cost, location, lack of awareness of immunisation services and their health benefits or other limiting factors.

Those with chronic diseases, underlying health issues or other risk factors such as age are at particular risk of major complications due to vaccine-preventable diseases and therefore should be targeted to ensure adequate immunisation.

Supply chains can be difficult to secure, particularly in countries that lack coordination or support of their immunisation programmes. Securing the appropriate resources, such as qualified health professionals, equipment and administrative support can present significant challenges.

Data collection on vaccine administration rates, side effects of vaccines and disease surveillance can often be difficult to achieve, particularly in isolated and under-resourced areas. Nevertheless, reporting incidents and monitoring disease spread are vital tools in combating global health threats.

## RECOMMENDATIONS

The WMA supports the recommendations of the Global Immunisation Vision Strategy (GIVS) 2006–2015, and calls on the international community to:

- Encourage governments to commit resources to immunisation programmes targeted to meet country specific needs.
- Recognise the importance of vaccination/immunisation through the continued support and adoption of measures to achieve global vaccination targets and to meet the Millennium Development Goals, especially four (reduce child mortality), five (improve maternal health) and six (combat HIV/AIDS, malaria and other diseases).
- Recognise the global responsibility of immunisation against preventable diseases and support work in countries that have difficulties in meeting the 2012 targets in the Global Polio Eradication Initiative<sup>1</sup>.
- Support national governments with vulnerable populations at risk of vaccine-preventable diseases, and the local agencies that work

<sup>1</sup> World Health Organization. Global Polio Eradication Initiative: Strategic Plan 2010–2012. Geneva, Switzerland: World Health Organization; 2010. Available at: [http://www.polioeradication.org/Portals/0/Document/StrategicPlan/StratPlan2010\\_2012\\_ENG.pdf](http://www.polioeradication.org/Portals/0/Document/StrategicPlan/StratPlan2010_2012_ENG.pdf)



to deliver immunisation services and to work with them to alleviate restrictions in accessing services.

- Support vaccine research and development and ensure commitment through the adequate funding of vital vaccine research.
- Promote vaccination and the benefits of immunisation, particularly targeting those at-risk and those who are difficult to reach. Comply with monitoring activities undertaken by WHO and other health authorities. Promote high standards in the research, development and administration of vaccines to ensure patient safety. Vaccines need to be thoroughly tested before implemented on a large scale and subsequently monitored in order to identify possible complications and untoward side effects. In order to be successful, immunisation programmes need public trust which depends on safety.

In delivering vaccination programmes, the WMA recommends that:

- The full immunisation schedule is delivered to provide optimum coverage. Where possible, the schedule should be managed and monitored by suitably trained individuals to ensure consistent delivery and prompt appropriate management of adverse reactions to vaccines.
- Strategies are employed to reach populations that may be isolated because of location, race, religion, economic status, social marginalization, gender and/or age.
- Ensure that qualified health professionals receive comprehensive training to safely deliver vaccinations and immunisations, and that vaccination/immunisations are targeted to those whose need is greatest.
- Educate people on the benefits of immunisation and how to access immunisation services.
- Maintain accurate medical records to ensure that valid data on vaccine administration and coverage rates are available, enabling immunisation policies to be based upon sound and reliable evidence.
- Healthcare professionals should be seen as a priority population for the receipt of immunisation services due to their exposure to patients and to diseases.

The WMA calls upon its members to advocate the following:

- To increase awareness of national immunisation schedules and of their own (and their dependents) personal immunisation history.
- To work with national and local governments to ensure that immunisation programmes are resourced and implemented.
- To ensure that health personnel delivering vaccines and immunisation services receive proper education and training.
- To promote the evidence base and increase awareness about the benefits of immunisation amongst physicians and the public.

## WMA Statement on Violence in the Health Sector by Patients and Those Close to Them

*Adopted by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

### PREAMBLE

All persons have the right to work in a safe environment without the threat of violence. Workplace violence includes both physical and non-physical (psychological) violence. Given that non-physical abuse, such as harassment and threats, can have severe psychological consequences, a broad definition of workplace violence should be used. For the purposes of this statement we will use the widely accepted definition of workplace violence, as used by the WHO: "The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation".

Violence, apart from the numerous health effects it can have on its victims, also has potentially destructive social effects. Violence against health workers, including physicians, not only affects the individuals directly involved, but also impacts the entire healthcare system and its delivery. Such acts of violence affect the quality of the working environment, which has the potential to detrimentally impact the quality of patient care. Further, violence can affect the availability of care, particularly in impoverished areas.

While workplace violence is indisputably a global issue, various cultural differences among countries must be taken into consideration in order to accurately understand the concept of violence on a universal level. Significant differences exist in terms of what constitutes violence and what specific forms of workplace violence are most likely to occur. Threats and other forms of psychological violence are widely recognized to be more prevalent than physical violence. Reasons and causes of violence in the healthcare setting are extremely complex.

Several studies have identified common triggers for acts of violence in the health sector to be delays in receiving treatment and dissatisfaction with the treatment provided.<sup>1</sup> Moreover, patients may act ag-

1 Carmi-Iluz T, Peleg R, Freud T, Shvartzman P. Verbal and physical violence towards hospital- and community- based physicians in the Negev: an observational study BMC Health Service Research 2005, 5:54. Derazon H, Nissimian S, Yosefy C, Peled R, Hay E. Violence in the emergency department (Article in Hebrew) Harefuah. 1999 Aug;137(3-4):95-101, 175. Landua S F. Violence

gressively as a result of their medical condition, the medication they take or the use of alcohol and other drugs. Another important example is that individuals may threaten or perpetrate physical violence against healthcare workers because they oppose, on the basis of their social, political or religious beliefs, a specific area of medical practice.

A multi-faceted approach encompassing the areas of legislation, security, data collection, training, environmental factors, public awareness and financial incentives is required in order to successfully address the issue of violence in the health sector.

In addition, collaboration among various stakeholders (including governments, National Medical Associations (NMAs), hospitals, general health services, management, insurance companies, trainers, preceptors, researchers, police and legal authorities) is more effective than the individual efforts of any one party. As the representatives of physicians, NMAs should take an active role in combating violence in the health sector and also encourage other key stakeholders to act, thus further protecting the quality of the working environment for healthcare employees and the quality of patient care.

This collaborative approach to addressing violence in the health sector must be promoted throughout the world.

## RECOMMENDATIONS

The WMA encourages National Medical Associations (NMAs) to act in the following areas:

**Strategy** – NMAs should encourage healthcare institutions to develop and implement a protocol to deal with acts of violence. The protocol should include the following:

- A zero-tolerance policy towards workplace violence.
- A universal definition of workplace violence.
- A predetermined plan for maintaining security in the workplace.
- A designated plan of action for healthcare professionals to take when violence takes place.
- A system for reporting and recording acts of violence, which may include reporting to legal and/or police authorities.
- A means to ensure that employees who report violence do not face reprisals.

In order for this protocol to be effective, it is necessary for the management and administration of healthcare institutions to communicate and take the necessary steps to ensure that all staff are aware of the strategy.

**Policymaking** – In order to help increase patient satisfaction, national priorities and limitations on medical care should be clearly addressed by government institutions.

The state has obligations to ensure the safety and security of patients, physicians, and other healthcare workers. This includes providing an appropriate physical environment. Hence, healthcare systems should be designed to promote the safety of healthcare staff and patients. An institution which has experienced an act of violence by a patient may require the provision of extra security, as all healthcare workers have the right to be protected in their work place.

In some jurisdictions, physicians might have the right to refuse to treat a violent patient. In such cases, they must ensure that adequate alternative arrangements are made by the relevant authorities in order to safeguard the patients health and treatment.

Patients with acute, chronic or illness-induced mental health disturbances may act violently toward caregivers; those offering care to these patients must be adequately protected.

**Training** – A well-trained and vigilant staff supported by management can be a key deterrent of violent acts. NMAs should work with undergraduate and postgraduate education providers to ensure that healthcare professionals are trained in the following: communication skills and recognising and handling potentially violent persons and high risk situations in order to prevent incidents of violence. The cultivation of physician-patient relationships based on respect and mutual trust will not only improve the quality of patient care, but will also foster feelings of security resulting in a reduced risk of violence.

**Communication** – NMAs should work with other key stakeholders to increase awareness of violence in the health sector. When appropriate, they should inform healthcare workers and the public when acts of violence occur and encourage physicians to report acts of violence through the appropriate channels.

Further, once an act of violence has taken place, the victim should be informed about the procedures undertaken thereafter.

**Support to victims** – Medical, psychological and legal counselling and support should be provided to staff members who have been the victims of threats and/or acts of violence while at work.

**Data Collection** – NMAs should lobby their governments and/or hospital boards to establish appropriate reporting systems enabling all healthcare workers to report anonymously and without reprisal, any threats or incidents of violence. Such a system should assess in terms of number, type and severity, incidents of violence within

against medical and non-medical personnel in hospital emergency wards in Israel Research Report, Submitted to the Israel National Institute for Health Policy and Health Services Research, December 2004

an institution and resulting injuries. The system should be used to analyse the effectiveness of preventative strategies. Aggregated data and analyses should be made available to NMAs.

**Investigation** – In all cases of violence there should be some form of investigation to better understand the causes and to aid in prevention of future violence. In some cases, the investigation may lead to prosecution under civil or criminal codes. The procedure should be, as much as possible, authoritative-led and uncomplicated for the victim.

**Security** – NMAs should work to ensure that appropriate security measures are in place in all healthcare institutions and that acts of violence in the healthcare sector are given a high priority by law-enforcement institutions. A routine violence risk audit should be implemented in order to identify which jobs and locations are at highest risk for violence. Examples of high risk areas include general practice premises, mental health treatment facilities and high traffic areas of hospitals including the emergency department.

The risk of violence may be ameliorated by a variety of means which could include placing security guards in these high risk areas and at the entrance of buildings, by the installation of security cameras and alarm devices for use by health professionals, and by maintaining sufficient lighting in work areas, contributing to an environment conducive to vigilance and safety.

**Financial** – NMAs should encourage their governments to allocate appropriate funds in order to effectively tackle violence in the health sector.

## WMA Resolution on the Abuse of Psychiatry

*Adopted by the 53<sup>rd</sup> WMA General Assembly, Washington, DC, USA, October 2002 and revised by the WMA General Assembly, Bangkok 2012*

The World Medical Association (WMA) notes with concern evidence from a number of countries that political dissidents, practitioners of various religions and social activists have been detained in psychiatric institutions and subjected to unnecessary psychiatric treatment as a punishment and not to treat a substantiated psychiatric illness.

The WMA:

- Declares that such detention and unwarranted treatment is abusive, unethical and unacceptable;

- Calls on physicians and psychiatrists to resist involvement in these abusive practices;
- Calls on member NMAs to support their physician members who resist involvement in these abuses, and
- Calls on governments to stop abusing medicine and psychiatry in this manner, and on non-governmental organizations and the World Health Organization to work to end these abuses; and
- Calls on governments to uphold the United Nations International Covenant on Civil and Political Rights, which states that “all persons are equal before the law and are entitled without any discrimination to the equal protection of the law.”

## WMA Resolution to Reaffirm the WMA’s Prohibition of Physician Participation in Capital Punishment

*Adopted by the 63<sup>rd</sup> General Assembly of the World Medical Association, Bangkok, Thailand, October 2012*

There is universal agreement that physicians must not participate in executions because such participation is incompatible with the physician’s role as healer. The use of a physician’s knowledge and clinical skill for purposes other than promoting health, wellbeing and welfare undermines a basic ethical foundation of medicine – first, do no harm.

The WMA Declaration of Geneva states: “I will maintain the utmost respect for human life”; and, “I will not use my medical knowledge to violate human rights and civil liberties, even under threat.”

As citizens, physicians have the right to form views about capital punishment based on their individual moral beliefs. As members of the medical profession, they must uphold the prohibition against participation in capital punishment.

Therefore, be it RESOLVED that:

- Physicians will not facilitate the importation or prescription of drugs for execution.
- The WMA reaffirms: “that it is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process, including its planning and the instruction and/or training of persons to perform executions”, and
- The WMA reaffirms: that physicians “will maintain the utmost respect for human life and will not use [my] medical knowledge to violate human rights and civil liberties, even under threat.”



## WMA Resolution on a Minimum Unit Price for Alcohol

*Adopted by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

Evidence from epidemiological and other research demonstrates a clear link between the price of alcohol and levels of consumption, especially amongst young drinkers and those who are heavy alcohol users.

Setting a minimum unit price at a level that will reduce alcohol consumption is a strong public health measure, which will both reduce average alcohol consumption throughout the population and be especially effective in heavy drinkers and young drinkers.

Some states are intending to set a minimum unit price in order to reduce the medical and social effects of excessive alcohol consumption.

The WMA supports states seeking to use such innovative measures to combat the serious public and individual health effects of excessive and problem drinking.

## WMA Resolution on Plain Packaging of Cigarettes

*Adopted by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

The WMA recognises that:

- Cigarettes offer a serious threat to the life and health of individuals that use them, and a considerable cost to the health care services of every country;
- Those who smoke predominantly start to do so while adolescents;
- There is a proven link between brand recognition and likelihood of starting to smoke;

- Brand recognition is strongly linked to cigarette packaging;
- Plain packaging reduces the impact of branding, promotion and marketing of cigarettes.

The WMA encourages national governments to support moves to introduce plain packaging of cigarettes, initially by the Federal Government of Australia, to break the brand recognition/smoking cycle and commends adoption of this policy to other national governments and deplores the legal moves being taken by the tobacco industry to oppose this policy.

## WMA Resolution in Support of Professor Cyril Karabus

*Adopted by the 63<sup>rd</sup> WMA General Assembly, Bangkok, Thailand, October 2012*

The WMA welcomes the bail granted on the 11<sup>th</sup> of October to the retired South African paediatric haematologist, 78-year-old Professor Cyril Karabus, as a positive step given his state of health; he has cardiac disease. Dr. Karabus had been detained in an Abu Dhabi, UAE prison since August 18<sup>th</sup> 2012. He was arrested in Dubai, whilst in transit to South Africa, owing to alleged charges emanating from a brief period that he worked in the UAE in 2002.

Professor Karabus was neither informed of the charges leveled against him nor the subsequent trial that was held in absentia relating to the unfortunate death of a child with acute leukemia under his care during his tenure in the UAE in 2002. His defense lawyer has also been unable to access any documents or files relating to the case that may assist in providing a fair defense.

Therefore,

The WMA General Assembly urgently calls on the authorities of the United Arab Emirates to ensure that Professor Karabus:

- Is guaranteed a fair trial according to international standards;
- Has access to the relevant documents or information he may require to prepare his defense.



## Memorandum of Understanding between the World Veterinary Association and the World Medical Association

### Preamble

**Acknowledging** that the World Veterinary Association [hereinafter referred to as WVA] is the recognized global professional veterinary organisation, founded in 1863, as an Association of 100 national veterinary medical associations supporting the global public good, including in animal health and veterinary public health internationally, food safety and the management of zoonotic diseases, animal welfare and disease monitoring based on veterinary education and evidence based science, representing the veterinarians by promoting their health and well-being.

**Acknowledging** that the World Medical Association [hereinafter referred to as WMA] is an international professional organisation representing physicians, founded in 1947, and is an independent confederation of 100 national medical associations whose purpose is to serve humanity by endeavouring to achieve the highest international standards in medical education, medical science, medical art and medical ethics and health care for all people in the world.

**Bearing in mind** that collaboration with the World Health Organisation [WHO] is a key focus of WMA's external relations because the WMA's core mission is to promote health and well-being of physicians and patients. Therefore the WMA commits itself to actively collaborating with the WHO in the areas of medicine with a strong focus on health systems development and strengthening public health programs.

**Bearing in mind** also that WVA has a longstanding collaborative agreement with WHO based on mutually agreed objectives that outlines activities for three-year periods. Main areas of involvement include lowering the burden of zoonotic diseases, increasing food safety and improving the global health status [healthy animals = healthy people]; raising the quality of teaching of veterinarians in food safety issues and zoonosis; addressing food safety; and responsible use of antimicrobials.

**Recognizing** that the World Animal Health Organisation [OIE] is the formally mandated international animal health standard setting body recognized by the World Trade Organisation [WTO] and that a long term collaborative agreement between WVA and OIE exists. That WVA has a Memorandum of Understanding with the Food and Agriculture Organisation of the United Nations [FAO] to support international [animal] health capacity building, that extends to public health and food safety-food security.

Both parties assist global efforts to redress pathogen emergence and re-emergence at the animal-human-ecosystems interface. WVA is an observer in the Codex Alimentarius Commission. Therefore it is important to have a Memorandum of Understanding between WVA and WMA as well.

**Conscious** of the prospects of a mutually beneficial relationship and the need to establish working arrangements within a framework of their respective rules, regulations and bylaws:

The WVA and the WMA [hereinafter referred to as "The Parties"] agree to the following:

### Section 1. Global Development Objective

The Parties will collaborate in The One-Health concept, which is a unified approach to veterinary and human medicine [veterinarians and physicians] in order to improve Global Health.

### Section 2. Scope of Cooperation

The scope of cooperation proposed by this Memorandum of Understanding will include

- 2.1 Support the concept of joint educational efforts between human medical and veterinary medical schools;
- 2.2 Support cross species disease surveillance and control efforts in order to prevent zoonotic diseases
- 2.3 Collaborate in the responsible use of antimicrobials with respect to critical antimicrobial lists for humans and animals.
- 2.4 Enhance collaboration between human and veterinary medical professions in medical education, clinical care, and public health and biomedical research.

### Section 3. Use of Logos

The use of the WVA-logo is specifically prohibited without prior written approval from WVA. The use of the WMA-logo is specifically prohibited without prior written approval from WMA.

### Section 4. Final Provisions

This Memorandum of Understanding reflects the professional collaboration between WVA and WMA on a basis of good-fellowship and shall represent the understanding of the Parties upon its signing by the WVA and the WMA.

## World-leading Plain Packaging Laws Squeeze Big Tobacco



*Steve Hambleton*

Australian smokers will soon be plucking their cigarettes, cigars and other tobacco products from drab olive brown packets emblazoned with graphic health images and warnings, as the world's first tobacco plain packaging laws come into effect.

In a measure that has drawn widespread international interest, the Australian Government has successfully enacted laws virtually eliminating the ability of tobacco companies to market their products through their packaging.

From 1 December all tobacco products sold in Australia must be in plain packaging, carrying large and explicit health images and warnings covering at least 75 per cent of the packet. Any product branding will be limited to words in small areas at the bottom and sides of packs.

The tough measures, strongly backed by public health organisations, came into effect after the High Court of Australia rejected a legal challenge mounted by the world's major

tobacco companies. The Australian Medical Association has been a strong advocate for plain packaging, which it sees as an effective tool for combating the glamorisation of smoking, particularly to young people.

In their challenge, British American Tobacco Australia, Japan Tobacco International, Philip Morris and Imperial Tobacco Australia, argued the new measures amounted to the acquisition of their brands and logos by the Government without just compensation, and should be ruled unconstitutional.

But the High Court found in favour of the counter argument from the Government that although the laws required the removal of trademarks from all cigarette packets, they did not weaken the companies' exclusive ownership of their trademarks.

"Although the Act regulated the plaintiffs' intellectual property rights and imposed controls on the packaging and presentation of tobacco products, it did not confer a proprietary benefit or interest on the Commonwealth," the High Court said in a summary of its judgement.

The Government has insisted that the laws were aimed solely at reducing the incidence of smoking.

"Research shows that industry branding and packaging design on tobacco products can mislead consumers about the harms of smoking, make smoking more appealing – particularly among young people – and reduce the effectiveness of health warnings on tobacco products," the Department of Health and Ageing said.

Attorney-General Nicola Roxon, who introduced the plain packaging legislation as Health Minister, and her successor Tanya

Plibersek, said the High Court decision was "a victory for all those families who have lost someone to a tobacco-related illness [and] a relief for every parent who worries about their child picking up this deadly and addictive habit".

"Plain packaging is a vital preventative public health measure, which removes the last way for big tobacco to promote its deadly products," the Ministers said in a joint statement. "Over the past two decades, more than 24 different studies have backed plain packaging, and now it will finally become a reality." But the tobacco industry has not given up the fight completely.

In addition to the High Court challenge, it has also backed action being taken by several countries against the legislation under trade laws.

The Dominican Republic has joined Ukraine and Honduras in complaining that the laws unfairly restrict trade and should be scrapped.

While the Caribbean nation is a tiny trade partner, exporting just \$20 million worth of goods to Australia in 2011, it is a major producer of cigars, and has lodged a formal complaint about the plain packaging laws with the global trade umpire, the World Trade Organisation.

The Dominican Republic Government formally notified of a trade dispute by requesting consultations with Australia "on certain measures concerning trademarks, geographical indications and other plain packaging requirements applicable to tobacco products and packaging" through the auspices of the WTO.

Both Honduras and Ukraine, both tobacco-exporting nations, are already well advanced in the preliminary steps that need to be taken before the matter proceeds to the WTO adjudication, having requested consultations with Australia over the measure.



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Under the WTO rules, if the matter cannot be resolved by negotiation within 60 days, the complainant can ask the WTO to set up a panel to adjudicate the case.

The issue has drawn significant international interest, with a large number of countries acting as third-party observers in the case.

The plain packaging laws are among a range of measures being taken by Australian governments at all levels to curb smoking, which is estimated to cost the nation \$31.5 billion a year in health expenses.

In its May Budget, the Federal Government slashed the duty-free allowance for travellers bringing tobacco products into the country from 250 cigarettes or 250 grams of tobacco to 50 cigarettes or 50 grams of tobacco, and two years ago it raised the tobacco excise by 25 per cent.

The range and appearance of health warnings on tobacco products has been increased, restrictions have been imposed on advertising tobacco products on the internet in Australia, and access to nicotine replacement therapies and other aids to quitting smoking is subsidised.

These more recent measures follow a long-standing nationwide ban on tobacco advertising and sponsorships, particularly of

sporting events, and the progressive introduction of laws prohibiting smoking at workplaces, sporting and entertainment venues and enclosed public places.

Official figures show the incidence of smoking among adults, particularly men, has been steadily decreasing in recent decades.

According to the Australian Bureau of Statistics, the proportion of men who smoke dropped from more than 27 per cent in 2001 to 23 per cent in 2008, while among women there was a more modest reduction from 21.2 to 19 per cent over the same period.

The AMA has been a long-standing advocate for plain packaging laws.

In mid-2009 it lobbied federal politicians to support the Plain Tobacco Packaging Bill introduced by independent Senator Steve Fielding, and eight months later threw its public support behind a decision by the Rudd Government to introduce plain packaging laws in 2012.

A year later, in July 2011, the Association made a submission to a Parliamentary inquiry in which it strongly backed the Government's Tobacco Plain Packaging Bill, and AMA officials were prominent advocates for the measure in the media.

Despite the breakthrough plain packaging laws, the Australian Government is under pressure to do more to combat smoking.

The AMA is among health groups critical of recent investments made by a public fund in tobacco companies.

The Government's \$73 billion Future Fund, set up to offset future public servant superannuation liabilities, invested almost \$38 million in tobacco company shares between December 2010 and February 2012.

The AMA believes it is simply irrational to have the good work that the Federal Government has done in tobacco plain packaging and tax measures undermined by Future Fund investments that help the tobacco industry to profit from selling a lethal substance.

The Future Fund has a responsibility to invest taxpayer money in a way that was consistent with the interests of the country and its people.

But the Government has so far firmly resisted pressure to dictate to the Future Fund how it should invest the money it manages.

*Dr. Steve Hambleton,  
President of Australian  
Medical Association*

## Estonian Physician on Strike

Estonian Medical Association and the Trade Union Association of Health Officers of Estonia organised a strike to fight for better working conditions (workload!!! 1 doctor does 2,5 "places") to medical staff, their salary and emigration policy!

First week of the strike – 1–7 october – in two biggest towns in Estonia (Tartu and Tallinn) strike was in action in ambula-

tory clinic – only children, oncological and pregnant patients were seen during elective hours. All emergency departments and ICU's of course were working.

Second week of the strike – 8–14 october – in Tartu and Tallinn – strike affects also stationary care (about 50% of the elective operations are postponed and those patients coming to hospital for evaluation/investiga-

tions are cancelled.) + ambulatory stop in smaller hospitals in Estonia. Third week – 15-smaller hospitals also stop/inhibit their stationary care.

Still going on...

After two weeks of strike no compromise has been made.

During strike, government and major political forces have gone really cheap – the media is publishing extreme numbers of doctors' salaries to show people that doctors are

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just a “bunch of greedy and dumb people who do not want to work”. Fortunately the nurses and orderlies are not attacked, the doctors’ take all the blame.

The demands of the strike are:

- changes in health care system in general (more money to health sector out of GDP, currently 6,3%)
- raising salaries for nurses, orderlies and doctors!
- Workload management!
- To stop people leaving Estonia

Negotiations about raising salaries of medical workers which started as much as 3 years ago, are still in progress. The salaries are still staying the same due to the fact that no official meetings have been successful.

The counter-act from the political side seems to be affecting media in producing unbelievable stories about over-paid doctors who don’t know how to treat people and only take their money out of pure greed.

The picture the media is painting of Estonian doctors right now is in really dark and gloomy colors and we have a hard time doing our jobs because there’s a lot of people lacking trust towards us.

(Currently minimum gross wages per hour are for doctors and dentists 7,16 € (resident have usually 0,8 place), nurses and midwives 3,83 € and caregivers 2,11 €. Minimum salary suggestions are respectively for year 2012 8,6/5,5/3 €, 2013 10/6,6/3,35 € and 2014 12/7,7/4,2 € per hour, for assistant doctors 60% of minimum doctors wages. For the residents a normal 40 hours work-week (at the moment it is paid for 32 hours per week).

## Emigrating healthcare professionals

(Doctors and nurses migration to the abroad have been increased, partly due to

adverse environmental healthcare situation, low salaries and high workload. This applies in particular to young doctors, for example, 28 (26%) of this year MD graduates did not even apply to residency, most of them went to work or study abroad. Healthcare workers leaving: year ‘04 439, ‘05 279, ‘06 196, ‘07 182, ‘08 188, ‘09 254, ‘10 398. From 2010 it costs 200€ to have certificate to work abroad as a doctor and it is valid for 3 month. Nurses leave have been doubled in a year (200 versus 100). In Estonia are approximately 2 nurses per 1 doctor, for 1000 inhabitant are 7,1 nurses, which is low in Europe.

Further, new doctors’ addition is not enough. Annual retirement age exceeds residency graduates from year 2014 (until 2027), for example, in 2023 is estimated to have at least 100 doctor less. In 2010 there was 4510 working doctors, 81 new doctors graduated residency but in same time went to abroad 146 and retired 126.)

## \*Campaign “I believe in the future of Estonian Medicine”

In association with Estonian Medical Students Association we have launched a campaign saying “I believe in the future of Estonian Medicine” to promote discussion among medical workers of what’s good in our system and what’s bad, and to show patients that there are still some doctors who want to stay here and treat our own people. The campaign t-shirts were sent to important people in Estonia and in all the hospitals, they were sold during the Estonian Doctors Days and one can order it on our webpage. Also little pins with the same slogan were handed out and those who wanted had the possibility to order fleeces with the same slogan. The idea was to promote discussion and that has worked out fine – people are talking to each other trying to figure out the weak spots in our system and finding solutions to make situation better. We have had quite many doc-

tors and associations telling us that we’re on the right track.

Next step of the campaign is a meeting between all different parties – the Ministry, the employers, employees, nurses, students, doctors etc. For the meeting all those who are joining in are asked to think of 3 goals that should be fulfilled by the year of 2020 (without thinking of any restrictions – money ie). The main idea is to make clear if we’re all aiming the same target or our ideas are totally different.

- the campaign is still in action but a bit less from our part.
- Now the minister of Social affairs has overtaken the idea about “chatroom” – what should we change by the time 2020.

Raili Ermel  
Estonian Junior Doctors Association  
16<sup>th</sup> October 2012

## Update on strike of Estonian doctors and nurses

*A preliminary agreement was approved on October 25<sup>th</sup> by Estonian Medical Association and Estonian Union of Hospitals and Minister of Social Affairs. The strike was stopped with the agreement. Agreement encompasses: Work intensity of doctors will be decreased by 20% in outpatient clinics and 16% in case of inpatient work. Trainees will be paid for longer hours (from 32 hours per week currently to 40 hours per week). Minimum salary of specialist doctors will be increased by 11% and that of nurses by 17,5%.*

# Happy Christmas 2012 – My First Christmas in 1964 was a truly White Christmas in London

My first English Christmas, on 25 December 1964, was a white Christmas, in a true sense. I was born in India, medically qualified in Pakistan and started work in Whipps Cross Hospital, East London. Those were happy days. I saw for the first time in my life that:

- The ground, cars, trees, rose bushes and buildings were covered with snow.
- The patients, other doctors, the matron, nurses, some nuns who were nurses, paramedics, porters and all other staff including cleaners were white.
- There were some male nurses. This was new for me. A charge nurse was called “Mr Rowbottom.” He was a cockney, born in east London within sounds of Bow bells.
- Pearly kings and queens came to hospital, sang carols and danced. I saw western dancing for the first time. England was peaceful, no war. Everyone looked happy and praised the Lord. I thought it was akin to what, I had been told, is in heaven.
- The ward sisters waited for a male consultant to cut the turkey, for Christmas lunch. He was wearing a Father Christmas costume. The atmosphere was magical.
- On the Christmas day ward round, as a houseman, I was pushing a trolley, full of bottles of wines and spirits. The consultant poured every patient’s choice in

a glass and the ward sister, with a rare smile, offered it to each patient, including the one with alcoholic cirrhosis, with a greeting “Merry Christmas & a Happy New Year.”

- I joined the nurses in carol singing, without opening my lips. I did not know carols and the singing tone, but I joined in. Since then, I am skilled in team working.
- Traditionally, some ward nurses, called “sisters” were very powerful under the Matron’s rule. They even influenced consultants in decision making. Ironically, I observed that one in three ward sisters were unkind to house doctors, especially to female doctors. However, their staff nurses were extremely nice. They were all nicer at Christmas time. Fortunately, I was alright, as I am cheerful, careful and tactful.
- Charge nurses were merrier at Christmas. I was amused, bemused and confused. What a new white world. As a child, I learnt that angles were white, made of light.
- Mr Rowbottom, a Charge nurse, advised me on my first night ward round on the Christmas eve “Doctor, write a laxative for each patient and the night nurse can choose to give it without waking you up to write for it.” Then he winked at me and said “If you keep their bowels open they would keep their mouths shut!”

- I was taken aback as I knew that winking, by a male or a female, is a sexual gesture in the East! I was startled to see that a Charge nurse was winking at me, a strictly heterosexual soul. I learnt later on that “winking” is a benign friendly gesture in the West. No Easterner needs to worry. This was the beginning of my strong interest in pioneering new disciplines of “Transcultural Medicine” and “Transcultural Litigation”.

That Christmas, I had thick black hair, a moustache turning upward, slim figure, and no sense of humour. I was a typical Easterner. Some nurses thought that I was very handsome. As a result of my age and westernisation over last 48 years, I shall not need a comb this Christmas and I am not be a slim guy anymore, but I have acquired the British sense of humour, including satire. I enjoy western music and dancing. I do my best to help people, as a caring doctor and I issue all prescriptions or certificates carefully. Yesterday was history, tomorrow is mystery, I enjoy today. I hope to remain a jolly good fellow for many more Christmases. As a jolly good fellow, I wish readers Merry Christmas and Happy New Year.

*Dr. Bashir Qureshi*

*E-mail: drbashirqureshi@hotmail.com*

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